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ABSTRACT

Prepared to disseminate the materials resulting from the institute to those who may want to replicate the model and for the many health professions faculty who were unable to attend but who requested information, this resource manual contains the four curriculum models developed by the participants in addition to excerpts from the lectures of some of the visiting faculty, and other materials. The curriculum models are intended to serve as examples of concepts, principles, and exercises which can be utilized in preparing health professionals for inner city work. The model titles are (1) Introduction to Outcasts, (2) Interdisciplinary Health Model, (3) A Curriculum Design for Health Service Practitioners, and (4) A Model for a Continuing Education Faculty Workshop on Inner City Ambulatory Health Centers. These are followed by a 46-item bibliography on neighborhood health centers (mostly journal articles, each with an abstract) and a 45-page listing of teaching-learning resources (bibliography, updating sources, organization data sources, and media). The five faculty presentations are titled "Consumerism in Health Care Delivery: Its History in Time and Space," by Leslie Falk, "Preparing Health Administrators for Future Roles," by James G. Haughton, "Health Care for Outcasts," by Nancy Milio, "Effects of Public Policy on Outcasts," by Nancy Milio, and "Decision-Making in Health Care System," by Nancy Milio. (WL)

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ED132255

Resource Manual
From
The Inner City
Work-Study Institute for
Health Professions Faculty
Summer, 1975

Program in Community Health Planning/Administration
College of Community Services
University of Cincinnati

In cooperation with:

Cincinnati Area Neighborhood Health Centers
and Related Facilities and the National
Association of Neighborhood Health Centers

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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The city and the university are historic cousins. The university was born in the city - in Alexander's great seat of learning in Egypt, in Salerno, Bologna, Paris, Prague. It was not, as Eric Hoffer has written, in the bracing air of steppes or forests that man changed the world. Everything was conceived and realized in the crowded stinking little cities of Jerusalem, Athens, Florence, Shakespeare's London, Rembrandt's Amsterdam...we will decay, we will decline if we can't make our cities viable. That's where America's destiny will be decided - in the cities.

Warren Bennis

Inner City Work-Study Institute for Health Professions Faculty

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Inner City Work-Study Institute for Health Professions Faculty: a Community-University Education Model

"Cincinnati is a particularly congenial place to be talking about the consumer in health care delivery - especially about the consumer-oriented center. In 1915, Wilbur C. Phillips and his wife, Elsie Cole Phillips, involved neighborhood residents in one of the very first health centers in the United States here in Cincinnati."[1]

With this bit of history on consumerism - the hallmark of the current neighborhood health center movement - the tone was set for Cincinnati's Inner City Work-Study Institute for Health Professions Faculty in the Summer of 1975. Sixteen educators from colleges and universities as far away as California attended this unique community-university project which addressed one of the nation's top health priorities: "the provision of primary care for medically underserved populations, especially those which are located in economically depressed areas" (P.L. 93-641). The educators came to gain first-hand experience in the delivery of inner city health services and in so doing, to contribute their expertise to solving problems in the delivery of those services.

The Institute was one of the Manpower Distribution Projects endorsed by the National Health Council and funded by the Bureau of Health Resources Development of the Department of Health, Education and Welfare. Unlike most of the other projects, which concentrated their efforts on student placement in scarcity areas, however, this one was designed to help health faculty more effectively recruit, motivate and prepare students for careers in health facilities and agencies serving inner city communities. This four-week faculty development effort included experiential learning and services in inner city health facilities; integrative seminars on campus with visiting lecturers, local community health leaders and the faculty of the Program in Community Health Planning/Administration; and group activities in which the educators developed curriculum models to take back to their institutions for implementation.

The Institute was designed to use the University of Cincinnati's experience as an urban university - specifically the community involvement of the Program in Community Health Planning/Administration - to help other universities educate and motivate their students for careers in the inner city. The Program, which offers both master's and baccalaureate degrees, has had a close working relationship with neighborhood health centers locally and nationally for some years.

Several of the major centers in the Cincinnati area are headed by its graduates and faculty have worked in the development of the local centers, serving on boards and providing consultation and training to both professional staff and consumers. Jerome Ashford, executive director of the National Association of Neighborhood Health Centers, has been a lecturer in the Program for two years.

Building on these positive relationships, a committee composed of Program faculty and community health center representatives planned a four-week education effort to provide other health professions faculty with similar experiences. The design of the Institute was based on several assumptions:

1) health facilities and agencies serving inner city communities require professionals who are motivated, educated, sensitive to inner city problems and needs, and competent to perform effectively.

2) students and faculty in health professions schools may not be aware of the opportunities and challenges of work in health planning agencies, health departments, neighborhood health centers, hospitals, community mental health centers, voluntary health agencies, health maintenance organizations, and other health facilities and agencies serving inner city communities.

3) faculty members who lack inner city work experience may not be able to serve as effective role models for students, and may not be able to make appropriate inputs regarding curriculum design, field placements, student counseling, and related activities.

4) as pointed out in the Carnegie report on The Campus and the City (1972),[2] institutions of higher education must consider community services as an integral part of their institutional mission.

The Institute provided the opportunity for sixteen faculty members, representing university programs in health administration, nursing, and health education, to spend each morning for four weeks in an inner city health facility in the Cincinnati area, under supervision of a faculty administrator, or preceptor. They experienced the challenges and frustrations of inner city health work, as they applied their expertise to solving problems found in their

placement. One educator commented that under different circumstances, he would have been paid two hundred dollars a day for the consultation given, but he felt the experience gained was a "quid pro quo" situation.

The service element was an essential component of the Institute and reflects the thinking of writers like Holleb (1972) who states: "The communities can no longer be viewed as 'living laboratories' to be studied and manipulated at the whim of the scholar or educator. To do this would be to misread the events of the decade grossly. A research or training program in a poverty area that does not engage the active cooperation of its residents and that is not perceived by them as fulfilling a useful purpose seems improbable today. A genuine partnership and a reciprocal relationship is essential to the success of any neighborhood-based program."[3]

In agreeing to participate in this cooperative educational venture, an administrator of one of the centers wrote: "It is of great interest to our board that programs of this nature work in two directions. One is helping the local neighborhood health centers with some of its problems, and second, helping health professions faculty better understand the needs of neighborhood health centers."

In addition to the experiential learning and service, the participants engaged in seminars in the afternoon on the University campus (see appendix A for complete program). They studied inner city health problems and health services with the faculty of the Program in Community Health Planning/Administration, augmented by specialists drawn from such institutions and organizations as Meharry Medical College, the University of Michigan School of Public Health, Simmons College, the National Association of Neighborhood Health Centers and the National Health Council.

The participants discussed with Nancy Milio, for example, the effects of public policy on outcast groups whom she describes as people of the central cities who have fewer health-sustaining resources and fewer of the essentials for health: food, housing, clothing, jobs and steady income.

"Health care policy," Dr. Milio declared, "must go beyond policy that pertains to personal health services, beyond policy that pertains to even traditional public health services...it must include policies that relate to the critical, health sustaining resources. Specifically, these are the amount and availability of food, decent housing, steady income, non-polluting forms of trans-

portation, education that raises the critical consciousness of people and good medical care services."

"Current health policy," she asserted, "is very narrow in focus, and does not necessarily allow us easy health promoting choices. Health care policy which sustains health would make health promoting choices the easy ones and it would make health damaging choices the hard ones."

Some of these same ideas were shared by Dr. Milio and other visiting faculty with a larger audience in a series of public lectures held during the Institute. The "Community Health Forum" (see appendix B) was aimed primarily at educating board members of inner city health agencies and organizations; however, it also facilitated interaction between the participants and consumers from the area. At the invitation of the staff of the Institute, these free public lectures were co-sponsored by the Cincinnati Health Department, the Xavier University Graduate Program in Hospital and Health Administration, and the University of Cincinnati College of Medicine, This cooperative mode led Dr. Robert O'Neil, then executive vice president of the University, speaking at an Institute luncheon, to refer to the Program as a bridge, not only to the community but also to other institutions on campus and in the metropolitan area.

The participants of the Institute were selected partially because of their commitment to utilize this experience to design and implement action to recruit, motivate and prepare their students for careers in inner city health programs. To begin implementation of this objective, the hard working educators spent their evenings reviewing resource materials and developing curriculum models to take back to their colleges and universities. These models were presented on the last day of the session to a panel of experts including Gary Filerman, president of the Association of Universtiy Programs in Health Administration; Dolores Lindsay, administrator of the Lincoln Heights Health Center; William Manseau, associate director, National Association of Neighborhood Health Centers; Stephen Plumer, educational consultant; Daniel Smith, National Area Health Education Centers Coordinator and Institute Project Officer; and the faculty of the U.C. Program in Community Health Planning/Administration.

Evaluation from the participants and their preceptors indicate that this education effort was effective. The preceptors in the health centers were satisfied with the expertise of the faculty members assigned them. They reported that the participants had completed such tasks as:

- developing a questionnaire to determine patient utilization and satisfaction
- organizing a new appointment system
- writing personnel policies and job descriptions
- evaluating center billing and reimbursement experiences
- revising nursing procedures for clinic and home care
- developing a guide for a problem-oriented medical record system
- working on a population research project
- proposing an educational career ladder

Immediately after the Institute and again, meeting as a group at the annual meeting of the American Public Health Association, the participants indicated a high degree of satisfaction with the achievement of the objectives of the Institute. With their new awareness of inner city health problems, they felt better able to counsel students about what to expect and to encourage them to meet the challenges and needs of this work. They all seemed to be incorporating their new knowledge and experiences in already existing courses; however, more formal curriculum revision is being attempted for the 1976-77 academic year. Several are planning to replicate this education model for their professional groups. One fundamental change, which was not specifically measured, but which was mentioned by almost all of the participants, was an attitude change. They reported acquiring a new respect for the strengths of the people of the inner city.

The participants and the preceptors are the best advocates of the Institute. The preceptors have indicated a willingness to join in such an educational endeavor again. This is deeply appreciated by the staff of the project, for it is recognized that without such a partnership any similar training program would be impossible. The participants are recommending the program to their colleagues and are asking for advanced courses for themselves.

Given this support, the Program in Community Health Planning/ Administration is seeking funding to repeat the Institute for additional groups of faculty from similar colleges and universities. It is also hoped that the model will be replicated by other communities.

This resource manual was prepared to disseminate the materials resulting from the Institute to those who may want to replicate the model and for the many health professions faculty who were unable to attend but who requested information. It contains the four curriculum models developed by the participants, in addition to excerpts from the lectures of some of the visiting faculty, and other materials. Although it is hoped that the curriculum models will serve as examples of the concepts, principles and exercises which can be utilized in preparing health professionals for inner city work, it should be recognized that these are not officially endorsed by the sponsoring organizations, the institutions represented by the participants, or the funding agency.

The health problems and needs of the inner city are stupendous; higher education can tackle just a piece of the problem: the maldistribution of health manpower. An Inner City Work-Study education program appears to be an effective means of providing in-service training for faculty and bringing about needed change in curriculum content, student counseling, student field placements, research and related activities. This Institute also demonstrates that higher education is a pivotal institution in reforming human service professions. As Holleb warns: "...(they) are the chief source of skilled professional manpower across the spectrum of employment. The teacher, health-care workers, urban planners, social workers, and other public servants critical in community development...receive their basic education in colleges and universities. Professional education includes more than the mastery of a body of knowledge and intricate techniques. Attitudes, value orientation and professional ethics are built into the educational process as well. Whether future professionals are attuned and equipped to deal with the poor and render services in poverty areas is in question, as is the very structure of several professions."[4]

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[1] Leslie Falk, M.D., "Consumerism in Health Care Delivery: Its History in Time and Space." Address given at the Inner City Work-Study Institute for Health Professions Faculty, University of Cincinnati, Summer, 1975.

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[4] Ibid. p. 44.

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CURRICULUM MODEL I Introduction to Outcasts

The concept of self-determination has been inherent in the development of this curricular proposal. The framework which is presented offers vast latitude in molding the content and methodology to fit the individual needs of the programs which plan to incorporate this subject matter on behalf of their students and on behalf of outcast groups.

This outline has been developed as a result of concerns generated through experiential and academic contacts with inner-city health care delivery systems in Cincinnati, Ohio. Over a one month period a team of college faculty with professional expertise in nursing, health administration and health education participated in an inner-city work-study program in order to pragmatize the development of better content and methodology for educating baccalaureate level health students for service to the inner-city poor and other outcast groups.

When a full array of health services is not located where people - the intended consumers - are or when prices or other program characteristics intervene as barriers, people become outcasts of health care. . . certain social groupings are more likely to become the outcasts of services - namely those already outcasts because of low income, poor living areas, old age, minority race, or majority sex. We, the designers of this curricular proposal believe that all students enrolled in health professionals' education programs have the right and obligation to gain knowledge of and practical experience with helping outcasts obtain and maintain new options for better health.

For the masses of students who become recipients of efforts to further refine this proposal and incorporate it into school curriculum, it is hoped that the following results will be attained:

1) The student will be able to identify outcasts groups and demonstrate an understanding of their specific problems resulting from their life circumstances.

2) The student will be able to demonstrate a grasp of the cultural characteristics specific to outcast groups as they are identified and a capability of utilizing this knowledge to effect better health care options.
3) The student will acquire evaluative skills so that he/she can assess the structure and quality of health care services being delivered to outcast groups.
4) The student will acquire knowledge of the legislative, regulatory, decision making and administrative process required for interventions on behalf of outcast groups.
5) The student will acquire skills which will assist outcasts in their efforts to plan, develop, and evolve changes which provide better choices for receiving quality health care.

It is recognized that all students will not become the cadre desired; however, out of the masses educated, it is anticipated that a self selected cadre will emerge with the commitment to become professional facilitators for specific outcast groups of their own area(s) of interest. It is this cadre who will have the interest and commitment which is necessary to bring about the relief so long sought by our disenfranchised groups. . . the outcasts.

This curricular proposal should foster educational endeavors which will enable the student to positively alter his/her attitudes and behaviors toward outcast groups. The specific course(s) developed for each school should provide the content and opportunity for interaction with others as needed to catalyze these changes. The following might be considered as examples of attitudes and behaviors/skills which are desirable for students completing the course(s). (The designers assert that these reflect socially defined values which are in some cases desirable and in other cases they are presumed to promote greater success in the efforts to plan, develop and evolve changes for quality health care.)

1) Demonstrate a respect for individual differences.
2) View the individual as a holistic being.
3) Demonstrate respect for individual rights, freedom and responsibilities.
4) Demonstrate the ability to respond to the changing needs of the community.
5) Demonstrate the ability to establish purposeful relationships with appropriate individuals and groups.

6) Demonstrate the ability to facilitate the involvment of the health professions through direct participation with civic and community groups.
7) Demonstrate the ability to identify and analyze factors which influence behavior related to health.
8) Demonstrate the ability to help others become more adept at group processes and interpersonal relationships.
9) Demonstrate the ability to provide health care for the masses while respecting the rights of the individual to reject that care.
10) Develop a personal code of ethics and a strength to uphold these ethics.

I. Arriving at a concept of Outcast Groups.

Content	Suggested Activities
A. Perspectives on population trends 1) The World 2) The U.S. 3) Regions	Classroom discussion and transparencies showing graphs of trends
B. Distribution of People 1) Spatial 2) Social, Preference 3) Socioeconomic Requirement	Resource Materials
C. Groups 1) Religious 2) Fraternal 3) Civic 4) Special Interest 5) Others	Panel of persons representing the different groups - The panel could be asked to respond to questions(s) given them prior to the discussion - concerning their function and place in the community.
D. Perspectives on Age	Classroom discussion Walking tour Visit to institutions associated with senior citizens
E. The Affluent and the Poor	
F. The White and the Non-white	
G. Urban/Rural Characteristics	Small group exercises followed by joint discussions (E-G)
H. Education 1) Levels 2) Quality	Mini-lectures and discussion with representatives from comprehensive health programs and the Education Association
I. Perspectives on Sexuality	Film strips Discussion

II. Survey of Methods to Measure Health Status of Groups.

Content	Suggested Activities
A. Fertility Ratio	- Study Guide with a pretest included
B. Family Index	- Library assignments
C. Occupation Index	- Audio-visual aids followed by discussion
D. Education and Intellect	
E. Socioeconomic Status	
F. Ethnology	
G. Racial Composition	
H. Environmental Factors	
I. Mental Stability	

III. Factors Affecting the Health Status of Outcast Groups.

Content	Suggested Activities
A. Variations in the Perception of Health-wellness	- Lecture-Discussion
B. Hierarchy of Need	- Begin first phases of problem solving - Assessment - problem identification i.e. - Case Study Field trips as observers Role playing Panel Discussion - various staff members from health centers, board members, clients and students
C. Occupation and Social Role	
D. Education and Intellectual Capacity	
E. Recreational, Religious Activities	
F. Language Usage	
G. Economic Status	
H. Level of Behavior Growth and Development	
I. Usual Cultural Patterns of Daily Living	
J. Usual Health Practices	
K. Relationship with "Significant Others"	

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IV. Health Care as a Right or a Privilege

Content

A. Investigating the Meaning of Health Care
   1) Holism vs. "Repair Services"

B. Financing Health Care
   1) General Taxes
   2) Social Insurance
   3) Private Insurance
   4) Personal Fees
   5) Industry
   6) Charity
   7) Voluntary

C. Consumerism in Health Care Delivery
   1) Historical Perspective
   2) Governmental Aspects
   3) Community or Neighborhood Involvement
      a. Advisory
      b. Policy making
      c. Organizations (unions, churches, etc.)

D. Evaluating Delivery Systems
   1) Organizational Structure
   2) Administrative Composition
      a. Consumer
      b. Provider
      c. Staff
      d. Board involvement
   3) Educational Programs
      a. Staff Development
         a.1) Orientation
         a.2) Continuing Education

Suggested Activities

Continue with Problem Solving Technique

- Formulating plans - planning for evaluation - implementation, i.e. - actual placement and functioning in a community agency according to primary interest (nursing, administration, etc.)

(Content under A-C should be observed during field assignments, accomplished through library resources, interviews with appropriate persons, contact with field instructor and periodic group sessions with classmates.)

Last Phase of Problem-Solving Technique

- Evaluate experience in health care setting.

- Presentation of findings.

- Evaluation of findings and presentation by peers, co-workers and professors.

- Recommendations for reassessment and further implementation.

Alternative or Additional Practicum

Many schools may be unable to offer practicums which are coordinated along with the proposed theory. An alternative plan to coordinated field experience is suggested as follows.

An extended practical experience which aims to give selected students an opportunity to attempt actualization of the concepts taught in the theory content is proposed. It is highly recommended that schools surrounded by a variety of outcast groups offer a summer course which allows students who have had the core content, to gain this practical experience.

Scope of the Summer Program:

Regularly scheduled seminars should be a part of the program. Early in the program, students could select topics of interest and then be responsible for preparing and conducting the seminars.

It would be most advisable to have the students work in small groups of two to four persons in experiential learning. The small group members would essentially be able to give support to each other as they individually experience cultural shock in the new community. A faculty member should be available for each small group to facilitate the group process and the learning experiences.

It is also advisable that the program provide transportation, parking and other approved expenses incurred on behalf of the program by the students in order that they make full use of the experience.

Suggested objectives for the program follow. These are not meant to be exhaustive and should be expanded.

1) The student will spend a given amount of time at the beginning of the program developing group awareness with the other students and faculty and will demonstrate by verbal contributions his/her willingness to participate in the total program.
2) Each student will be given the option to experience the day to day living of an outcast group family by spending a given period of time living in a family's home. A log will be kept of the experience and shared with the assigned faculty member and other students at the end of the experience.

3) Having observed a health agency board of directors meeting, the student will be able to identify in writing three strengths which would promote health for the community the agency serves.
4) The students will collectively develop an assessment tool for evaluating the quality of care of a locally designated health delivery service. The tool must be acceptable to the service's board of directors and the program faculty advisor and include at least financial support, administrative effectiveness, consumer involvement, quality of services and client and staff satisfaction.
5) The student will be able to identify specific problems and cultural characteristics of the Outcast Group through discussion in a classroom situation. The problems and cultural characteristics must be consensually validated by the other students and representatives of the Outcast Group.
6) Each small group of students will have been able to contribute to the efforts of a community health-oriented group (eg.: agency board of directors, people's health movement) to which they have been assigned. The contributions must be evidenced by improved or new delivery services.

Respectfully submitted,

Jessie Chase
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CURRICULUM MODEL II Interdisciplinary Health Model

Philosophy:

A creative learning climate is vital to the preparation of competent health professionals and must provide them the opportunity for risk taking, to become aware of their options, to acquire the capacity to choose, to change, to expand their array of chances available, to gain a greater control over their destinies, and to ensure a life long critical consciousness, raising participatory process.

Purpose and Setting:

To utilize the problem solving approach in relation to health care situations in order to give the students a methodology through which they can assess and evaluate reality situations found when working with outcast populations. This can be achieved through the following:

1) Experience in a variety of ambulatory health care settings and in the surrounding communities.
2) A theoretical base and simulated problem situations and discussions in the classroom.
3) Responses received (and recorded) from outcast groups and students expressed needs and concerns.

Students:

Students from a variety of health disciplines, interested faculty, consumers, board members and other interested people in the community.

Resources:

Sufficient funds are assumed to be available to cover the costs of a classroom fully equipped with audio-visual materials, tape recorders, slides, films, reprints and feedback mechanisms; a variety of ambulatory health care settings in inner-city and

rural areas; multidisciplinary faculty from the behavioral and social sciences; additional funds for a cooperative living arrangement with an "outcast" family or group for one weekend and guest speakers. Information sources and reference materials in the library should be easily accessible to students.

Competencies:

Students will be expected to:

1) demonstrate the ability to plan for and implement change in our socio-economic environment.
2) demonstrate basic knowledge of and skill in power-conflict resolution in political dynamics (includes terms such as grievance, bargaining, attitudes prejudice, stereotyping, values).
3) identify various role functions of consumers and providers in promotion of health.
4) demonstrate knowledge of the various basic components of organization, management, and delivery of health services from a local, national and global view.
5) identify the various sources of financing, allocations and the basics of constructing a budget.
6) demonstrate skill in the basics of evaluating performance.

General Methods of Implementation:

1) Introduction to the course giving a global overview (by faculty) on health and health care delivery systems.
2) Film, tape recorder and video-tape demonstrations.
3) Mini-lectures and discussions led by students and/or faculty.
4) Live demonstration on various interdisciplinary group interactions, family and group process.
5) Opportunity to visit another country regarding other health care delivery systems.
6) Programmed learning packages and practice sessions by students.
7) Utilization of various feedback mechanisms from students, groups of students and community.
8) Role playing and other simulated problem situations.
9) Utilization of various picture situation-perceptions methods (similar to TAT).
10) Opportunity for student options and creative presentation in classroom based on their interests.

11) Opportunity for a cooperative living arrangement with an outcast group or family for one weekend.
12) Opportunity to meet with various radical leaders, and leaders or militants from outcast groups.
13) Opportunity to meet with various power groups from the professional and affluent sectors.
14) Opportunity to meet with various legislators and other government officials.

EXAMPLE OF COMPETENCY DEVELOPMENT

Competency #2 Demonstrate basic knowledge of and skill in power-conflict-resolution in political dynamics (included in this are terms such as grievance, bargaining, attitudes, prejudice, stereotyping, and values)

Instructional Activities	Conditions when given	Performance: students will	Exercise to be handed in
1) Presentation of theoretical basis and demonstrate process of therapeutic communication and interviewing techniques. In small groups practice communication - and tape record. Explore relevant literature on communication and interviewing process. Show films and videotapes on one-to-one relationship.	role playing and group feedback. opportunity for replay have students give feedback before group without value judgment. opportunity for encouraging participation by raising questions, sharing concerns, and interests.	identify their own and each other's therapeutic and non-therapeutic questions and responses without value judgments.	Individual daily logs for critiquing by student and faculty members each week.
2) Explore literature on transactional analysis process and other group dynamic processes. Show films and videotapes on one-to-one, family, and heterogenous group process.	simulated problem situations and feedback on discussion of resistances, common threads of various phases of group process and leadership skills.	identify their own and each other's strengths and limitations without value judgments.	
3) Explore literature on Gestalt and psychodrama. Show films and videotapes and presentation of theoretical components.	opportunity for group involvement and feedback without value judgments.	demonstrate a more positive self image and behaviors	

Instructional Activities	Conditions when given	Performance: students will	Exercise to be handed in
4) Explore literature on definition of terms in political dynamics.	when given a list of various terms and discussion of same.	give common sense definitions with personalized examples of 90% of terms.	
5) Explore the literature on various values, attitudes, prejudice, stereotypes, and folkways of various outcast groups. Show videotapes.	opportunity for group discussion and feedback. opportunity for a co-operative living arrangement with an outcast group or family for one weekend and feedback to group about experience without value judgment.	identify commonalities and differences of various groups in relation to self without value judgment.	Individual student and faculty conferences scheduled by either student or faculty.
	utilization of picture situation-perceptions methods/or tools (similar to TAT).	identify own attitudes prejudices, stereotypes in relation to promotion of health.	
6) Exploration of the literature on pluralism with focus on power-conflict struggles and resolution and presentation of theoretical components.	opportunity for discussion. simulated problem situations resulting in group consensus.	identify various factors and forces influencing power-conflict struggles and dilemmas.	

Instructional Activities	Conditions when given	Performance: students will	Exercise to be handed in
Show videotapes and tape recordings on various power-conflict situations in a variety of health care settings and contexts.	opportunities for student options based on their needs.	identify possible alternative courses of action in power-conflict resolution in relation to self.	Final exam based on problem solving exercises.
7) Show videotapes and present tape recordings on various power-conflict situations in a variety of business and governmental levels and settings.	field work in various ambulatory health settings, i.e. board meetings, and in the surrounding communities. opportunity to have a discussion with various radicals, militants or leaders and consumers of outcast groups and other power groups, and other professionals from the political arena. opportunity to relate their classroom and community experiences to professional competency. opportunity for encouraging participation by raising issues, questions, concerns, without value judgment.	identify strengths and power-conflict areas. share concerns, raise issues, and questions. have helped to solve one important problem area in an ambulatory health care setting and in the surrounding community.	Student evaluation of the course and faculty.

A Model Self Instructional Package

Instructor's Name	Dr. Dull
Institution	Everyman's University
Segment	Finance - Problem solving basis
Intended Students	Human Service Types
Topic	National Health Insurance
Time	Two Weeks

Introduction

As future workers in the health field you will need to know the great changes taking place in the area of national health insurance. Since there are many proposed health insurance plans, you will need to know the basics involved in each. The kinds of practices in which you will be involved when you graduate will most certainly be influenced by whatever type of insurance program is instituted. This knowledge (along with your experiential learning) would hopefully prod you to prod your politicians to pass legislation favorable to the outcast population and the kinds of health centers in which you will be working.

(Overview and Objectives)

Overall Objectives (Cognitive)

You will be able to describe at least five basic principles of three proposed national health insurance programs. Broken down, this means:

1) Be able to name three national health insurance programs and
2) be able to list four basic principles of each.

Attitudinal

Hopefully, you will request additional information on national health insurance. There is, by the way, a vast selection of literature on national health insurance on reserve in the library.

Practice Cycle 1

Input

One proposed policy (there are seven) is the Cash-Poor Policy named after its congressional initiators. Much of the present system will remain the same. Individuals must contribute one-half of the entire cost of hospital bills. Prevention is not emphasized. No payment is made to individuals for general, preventive physical examinations. Dental and psychiatric work is not included. Private health insurance companies will have major control. Federal government acts as regulator.

Practice

1) Does it seem that present system will remain the same?
2) Is dental care included?
3) Is prevention emphasized?
4) Will the government act as regulator?
5) In whose hands would the insurance industry remain?

Feedback

1) yes;
2) no;
3) no;
4) yes;
5) private.

Practice Cycle 2

Input

Another model is the Nice to Have national health insurance policy. Most Americans will pay twenty percent of a total yearly premium. Federal government will pay eighty percent. Federal government will become issuers of health insurance policy. There would be no private ownership. All health care, including dentistry, will be completely covered. No deductibles are required. A preventive medicine clinic would be set up for every 30,000 population group.

Practice

1) What will be placed in each neighborhood?
2) For what payment will each individual be responsible?
3) The private health insurance industry will remain in charge. T or F
4) Dentistry is not included. T or F

Feedback

1) A preventive medical clinic.
2) Twenty percent of yearly premium.
3) False.
4) False.

Practice Cycle 3

Input

The compromise model of national health insurance policy. Any individual making over $8000 will be required to pay the first $100 ($100 deductible) of all medical and dental bills each year. The federal government will pay the deductible for those with incomes below $8000. Private insurance industry will remain intact. The individual must pay entire yearly premium. No preventive emphasis and no neighborhood clinics.

Practice

1) What is amount of deductible?
2) Will there be preventive medicine health centers?
3) Who will run the insurance business?
4) Is dental care included?

Feedback

1) $100.
2) No.
3) Private industry.
4) Yes.

Practice Cycle for Overall Objective

Input

There are seven proposed national health insurance programs.

Three of them are:

1) "Cash-Poor",
2) "The Nice to Have", and
3) "Compromise-OK" policy.

Cash-Poor: system remains the same; federal government acts as a regulator. Control is still in hands of private insurance companies. And the individual needs to pay one-half of entire medical bill.

Nice to Have: Americans with over $10,000 salary pay twenty percent of annual premium. Government pays it for those with incomes under $10,000. There would be no private ownership of insurance industry. Established would be neighborhood preventive medicine clinics. Dentistry is included.

Compromise-OK: Individuals making over $8000 will be required to pay first $100 of all medical, dental bills each year. Federal government will pay deductibles for those below $8000. Private insurance industry will remain intact. No preventive emphasis and no neighborhood clinics.

Practice

1) What program would have the greatest financial impact on the individual?
2) Which proposed policy has no preventive emphasis?
3) What main differences exist between the three proposed policies?
4) Who runs health insurance business in "Nice to Have" proposal?

Post Test

1) Give the names of the three mentioned proposed policies.
2) List four characteristics of each proposal.
3) What is the federal government's responsibility in the Nice to Have policy?
4) What proposal is concerned with prevention?

5) What is the criterion for the establishment of preventive medical centers?
6) Attitudinal Post Test: Questions on national health insurance at a later time during discussion and use of reserve books in library.

Respectfully submitted,

Dorothy Oechsler
Michael Rosko
Paul Taylor
Phyllis Wentz

CURRICULUM MODEL III
A Curriculum Design for Health Service Practitioners

I. Curriculum Platform

The Inner City Work-Study Institute provided the thrust for the writer's thinking on the need for restructuring the entire approach for educating health providers. With each new speaker it became increasingly apparent that the prevailing problem in the health delivery system was not a lack of programs but rather effective outcomes. Therefore, the recurring theme became "How do you get good intentions to turn into good outcomes!" Other equally important issues were raised such as:

1) What are the conditions for health?
2) What are the resources for health?
3) What are the effects of public policy on the health of people?
4) Are our health programs ideological or data-based?
5) Do we encourage students to behave the way we want them to behave outside of school?
6) Within what context are we organizing for health care?
7) What are the constraints with which the health professional must deal?
8) When do I accept a constraint?
9) When do I go out to change a constraint?

These and other similar questions showed reflectively that the divisive hierarchical structure of our health system corresponds to the structure and design of our society. The roots of the problem are far too deep for a few reformist measures to eradicate. Until the entire system is shaken and reordered along more equitable lines, we will be continually applying bandages to a cancerous lesion.

This Institute brought together some of the greatest minds in the health care arena. It was heartening to note provocative presentation of critical issues in health care delivery, analysis of the structural organization of health systems, and pervasive exploration of policy and decisional components of

health. This great and enlightened group disrobed from the usual professional wrappings and this writer witnessed for the first time an intellectual exchange that was indeed inspiring. The dialogue took on deeper dimensions as colleagues "agreed to disagree" and held up to the light of day issues heretofore hidden with delusional rhetoric.

We as health professionals can not afford the luxury of thinking we have the answers and go start our efforts with the recipient again. Rather, what is crucial at this point are the providers! We must reckon with the fact that no amount of health care can place into perspective the strivings, longings, and aspirations of a people who are threatened by an indifferent society. As health professionals we have a commitment to stroke the positive, analyze the negative and address our accountability by constructive action.

Inherent within this projected curriculum for health science students is the needed flexibility and realistic framework for providing effective workers to deal with inner-city groups, special community groups, and the total population. It allows for the first time a somewhat comprehensive approach to a long-standing problem. This curriculum in term of outcomes negates the need for continual and inept attempts to provide providers sensitive to the needs of the poor. It will provide a sensible (or radical depending on your orientation) open-ended alternative to those heretofore locked into one dead-end job after another. When workers are allowed to excel within known parameters and abilities they are less likely to be bullied into hardened, insensitive, frustrated and anxious people who constitute one of the major breakdowns of our health delivery system. This open-ended acceleration where efforts are rewarded based on evaluative outcomes will make each provider a possessor of the "piece of the rich." No position within the system will be viewed as dead-end and unimportant (our educational program must reflect and generate this type philosophy) but, rather a part of the orchestration of health care.

This curriculum approach embodies the concept that health professionals must be brought into accountability for outcomes. There should be some central nucleus for the modus operandi. This nucleus must be visionary and flexible, thereby allowing for the individuality of the students of the health professions.

In a field which includes over 125 recognized occupations and 250 specializations of these, the corresponding educational

programs are suffering profusely from lack of coordination. They not only overlap but are usually long, expensive, and theoretically rather than practically oriented. Generally workers are moving towards even greater specialization, further reinforcing the segmentation of health care delivery. Many workers have been forced to be so preoccupied with credentials and pretensions of professionalism, that they are becoming overtrained. Efforts to implement new educational concepts that will radically change this situation rather than reinforce it are difficult because of bureaucratic controls and constraints (such as licensure and accreditation). The long educational route presently necessary to gain job credentials are in large part responsible for personnel shortages. This is infuriating not only to consumers, who suffer from the resulting low quality care, but equally to those who want to enter the health field but lack access to the training. Though some token efforts have been made, such as shortening programs from four to three years (this just means going to school year round), admissions are still tightly controlled, and generally curricula are dry, intimidating and highly pressurized.

It is difficult to generalize about programs educating other professionals; however, in nursing as in some other disciplines there are "career ladders" of various types, but in the words of one student you "start at the bottom and work down." That is, you can advance to a certain level through work experience, but if you want to go farther still, you must quit, go back to school and virtually begin again.

Community clinics and institutional inservice education programs often have training courses for their own personnel which are usually more flexible and practical than college programs, but other institutions (colleges and universities) will rarely accept these workers' qualifications because training varies so much from clinic to clinic. Such community training programs reflect the irresponsibility of those who design and fund them. They are intended to crank out large numbers of people as quickly as possible, with no thought of providing more than direct services to a few more people for a temporary period of time, as specified by the grant money. In many cases, trainees are merely being prepared to fill positions already held by other poor community people; not to actually ascend the career ladder.

To avoid this type of careless planning that benefits neither the worker nor client, changes must be made in the whole concept behind health care education. Educational programs for all health workers should be inter-disciplinary, starting with

"care" curriculum that all health workers would go through together on an equal basis. Integrated with this concept is that of the career ladder. After a year or so of the common core curriculum, some students would funnel into the institution, working full-time (or part-time while continuing training part-time). They would have the option of coming back for more education anytime to a level on the ladder commensurate with the experience they had gained (determined by competency-based testing); others would remain in training for longer periods of time, and then branch off, again with options open for returning. In this way, anyone with ability and desire could work at his or her own rate of speed up to the most skilled positions, whether neurosurgery or hospital administration. Such open channels between multiple entry and departure points are an effective way of eliminating occupational barriers as well as class, sex and racial ones.

Most present educational programs are designed to work within the system, yet they can also be seen as intermediate steps toward more far-reaching change. These include coordinating college academic programs with hospital experience, giving graduates first priority for jobs in that hospital; doing task analysis of jobs by defining people by what skills they have rather than job title, and credentialing them accordingly; doing more in hospital education and upgrading of all present employees; pulling motivated students from minority communities and intensively preparing them to succeed in professional schooling. Nonexploitative experimentation must be encouraged to determine what systems work best for recipients and providers and why, with the overall goals of combining quality care with meaningful and equal employment opportunities.

The following is a synthesis of some of the key components of a national health plan, aimed at changing our system of health care delivery. Some are widely accepted while others have been points of debate among health professionals. The list is neither complete nor static, actually raising more questions than it could hope to answer. But, it is a starting point -- and an important one at that.

1) Cost and financing of a national health plan
2) Distribution of facilities
3) Training and distribution of health personnel
4) Control of facilities
5) Community health councils
6) Regional health councils
7) National health councils

Due to the provocative nature of each of these platforms the writer will only deal with training and distribution of health personnel. The sequence of this presentation will proceed as follows:

1) philosophy
2) conceptual framework
3) objectives
4) terminal behaviors (outcomes)
5) curriculum sequence

II. Philosophy: School of Health Science Practitioners

Philosophers have and are attempting to arrive at some understanding of the nature of man himself, of the nature of reality and truth, and knowledge of the nature of the educational process, of the nature of society and the universe. Moreover, each system of philosophy attempts to pull its sets of beliefs concerning these issues into some degree of synthesis or unified whole. It follows then, that health care practitioners must also be concerned with these continuing philosophical issues, and thus identify a set of beliefs or assumptions upon which they wish to operate.

The set of beliefs set forth herein is the focus guiding the development of an educational program for health professions. It is believed that education for health care is a legitimate field of higher education and a legitimate field of professional education. As a field of higher education it belongs within the university. As a field of professional education it is concerned with developing students broadly for living and for rendering health care which is based upon depth of understanding, upon the formulation of judgments, upon problem-solving and upon decision making.

The knowledge needed by the health professional may be seen as falling roughly into four overall categories. First, there is the broad category of general and liberal knowledge, derived from the humanities, which is concerned with the development and enhancement of the individual. Second, there is the knowledge derived from the quantitative, behavioral, and biological science fields which provide the foundations upon which the professional discipline is based. Next, a distinctive rationale to guide the practice of health care must be conceptualized from these foundational fields. Finally the rationale must be tested and applied at the actual point of delivery.

Philosophically speaking we have three tasks in education. They are:

1) to master the lawful world we live in;
2) to free the potentials of every person so he or she can imaginatively build the kind of world he or she wants (within broad limits imposed by the culture in which he or she lives)
3) to cultivate among all people a respect for the rights of others and motives of mutual consideration.

Education is then regarded as the means for enhancing individual and social worth.

Knowledge has reached such immense proportions that any one person can acquire only a small fraction of it in his lifetime. Knowledge for its own sake, however, is no longer recognized as a proper educational goal. Knowledge is regarded as an implement for wise self direction. It is acquired through direct perception of the things that make up the world, and through a continuing reasoning about and evaluation of one's own perceptions. The reasoning and idea - generating portion of the process is accompanied by practical trial of the behavior suggested by the ideas. Three ideas or hypotheses are tested empirically. From this testing arises a sense of the value and its usefulness in overt actions. From this testing also are derived additional understanding of the phenomena, and further refinement of concepts. This re-affirms still more strongly the necessity of preparing a practitioner who thrives for himself, who can alter approaches based on the newly discovered knowledge, who is adept in problem-solving and who recognizes every day of his career, that his education has, in fact, scarcely begun.

The health science practitioner is looked upon as having distinctive contributions to make to improving the health models of society. The health science practitioner stands on a "par" with other professional disciplines and in so doing must function independently in some situations but also collaboratively in situations which require the collective judgments of several different professions.

The service rendered by the health science practitioner should not be mitigated by the time, place or circumstances. The dominant responsibility is to the population as a whole; therefore, health care directed to individuals, families or groups becomes a valid component of the practice as it intrinsically relates to and contributes to the health of the total population.

III. Curriculum Conceptual Framework

This writer subscribes to the major thrusts of Bevis Conceptualization of a systems approach to curriculum organization. This conceptualization has been modified and adapted by the writer in designing the conceptual framework herein presented.

The knowledge needed by the professional practitioner requires an operational framework of clear concepts out of which theories can develop. The professional practitioner unifies the principles and concepts basic to primary care to describe, to explain and to predict man in his entirety.

The curriculum is organized around three major processes:

1) The intracognitive process,
2) The intercognitive process,
3) The extracognitive process

These processes provide a framework for dealing with complex health problems and their changing relationships. The four subprocesses of assessing, planning, implementing and evaluating repeat themselves in a spiralling, continuous fashion and provide the base from which many health actions can proceed. The major processes and the subprocesses within this framework can be examined, analyzed, and pursued deliberately by the professional practitioner as he or she intervenes for clients with whom he or she functions.

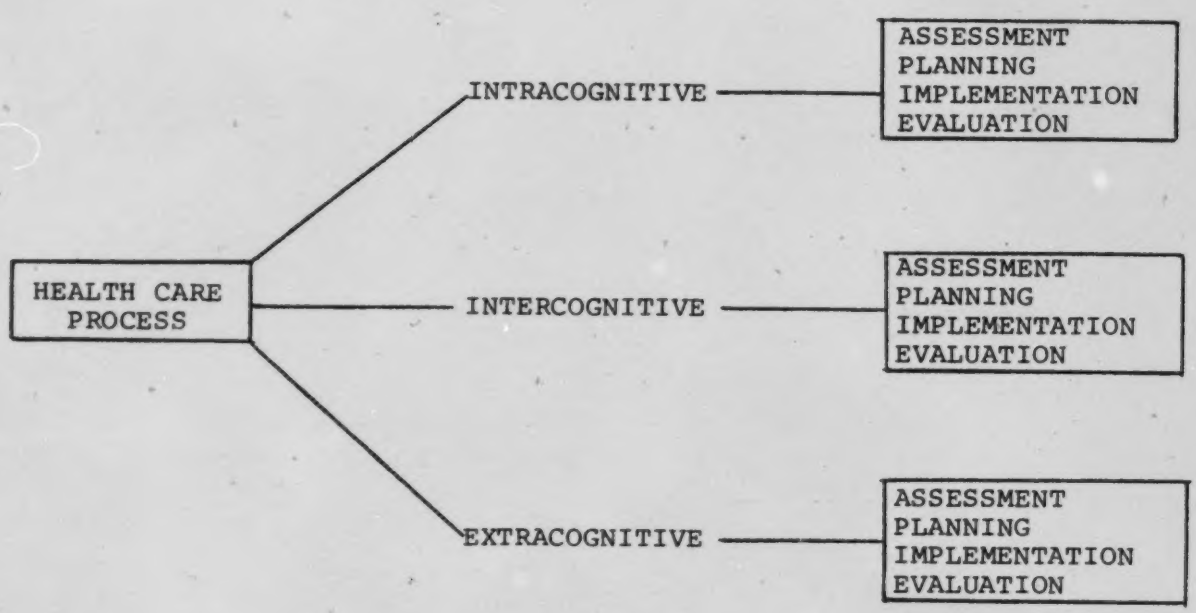
The intracognitive process involves those behaviors that promote the optimal functioning of all internal biochemical, and physiological life processes, all biological life processes, and individual personality formation and expression of the individual.

The intercognitive process involves those behaviors that promote optimal functioning of two or more people. This includes the health practitioner and the client, the health practitioner and other health workers, the health practitioner and other professionals, the client's family and the health practitioner, and surrogate families and the health practitioner.

The extracognitive process involves those behaviors that promote optimal functioning of communities. "Community" is here defined as "a group of people having common organization and mutual interest." Health practitioners engage in activities in communities, whether the community be local or worldwide; this involves working with health care systems, governmental agencies, citizens groups, and proprietary agencies.

Any activity that reduces threat to the health of the community or promotes the health of communities is a community activity. Any activity that the practitioner engages in that facilitates coping by a community qualifies as a community activity.

In order to develop the above into a useful conceptual tone, the following scheme is presented as interpreted by the writer.



IV. Curriculum Objectives: Health Science Practitioner

The central purpose of the Health Science Curriculum is to prepare a professional practitioner. A program of studies is implemented which will enable the student to:

1) develop ability to identify health problems, utilize the health care process, formulate objectives, and predict and evaluate outcomes.
2) understand self and the world in which he or she operates.
3) develop and operate upon a set of personal values.
4) develop and operate upon a set of values in relationship to the health profession, its heritage, social purposes and contributions.
5) gain depth in the appreciation of the dignity and worth of the individual.
6) become self-motivating self-directing, self-evaluating and able to assume responsibility for one's own actions.
7) develop ability to communicate, verbally and in writing, with individuals and groups, for effective interchange of ideas.
8) develop skills in ministering to the physical, emotional, and spiritual needs of individuals of all ages, who are in various stages of illness and health, in the varied environmental settings in which health care is practiced.
9) develop increasing ability to function independently in health care situations.
10) develop ability to function as an independent practitioner and collaborating member of the health team.

V. Terminal Behaviors: Health Science Practitioners

As must be reflected in level objectives (to be developed collaboratively with other health colleagues) the faculty expects its students to become increasingly sophisticated in the use of the "health care process" as they progress throughout the program. To reiterate, also it is embodied in the philosophy that the professional practitioner is looked upon as having distinctive contributions to make to the solution of the problem of illness and disease and distinctive contributions to make to improving the health level of society. Towards this end the following behaviors are expected of graduates:

1) the graduate will be able to identify health problems, utilize the health care process, formulate objectives, and predict and evaluate outcomes.
   - 1.1 Utilize the skill of perception, observation and communication as a basis for action
   - 1.2 Demonstrate effective provider-client relationships based on sound goal settings, establishing priorities, and designing methods to resolve health care issues
   - 1.3 Initiate and complete health actions necessary to accomplish predetermined goals
   - 1.4 Collaborate and coordinate actions on behalf of the client
   - 1.5 Recognize and appraise the client's behavioral manifestations as they correlate with health activity
2) the graduate will independently discover personal uniqueness and will use self to enhance personal professional growth.
3) the graduate will examine present life experiences of each client and seek methods appropriate for coping irrespective of the setting.
4) the graduate will foster ideals for the profession while functioning realistically within a continually changing framework.
5) the graduate will display an appreciation of self and the uniqueness of individual character that propels and embraces challenges toward personal and professional actualization.

6) the graduate will conceptualize the significance of health as it relates to man and when necessary, assist the client in placing into perspective his or her life strivings and goals.
7) the graduate will participate in life experiences with in the health arena to the end that he may utilize relevant knowledge and formulate new concepts which will enhance the quality of life for mankind.

VI. Projected Curriculum

A. First Year

1) Basic courses as prescribed by interdisciplinary collaboration on what are the beginning "core" courses for the health science student.

1.1 One beginning course in the student's professional choice that will equip him or her with a salable skill and a departure point.

Example: Health Practitioner I
Nurse's Aid
Hospital Administration Aid
Medical Aid
Social Aid
Psychology Aid
etc.

1.2 This first year will require extensive counseling and retrieval service aimed at the special needs of students, ie. those from minority and disadvantaged populations.

1.3 This program should be a part of a national plan so as to provide mobility for the student and to meet varying needs of participating communities.

1.4 Special faculty preparation for this form of educational exercise should be initiated by the participating educational institutions.

1.5 This curriculum will be operationalized from the conceptual framework using the "health care process" as the structural component.

B. Second Year

1) Additional basic core courses as prescribed by interdisciplinary collaboration on what second level courses are required.

1.1 Additional sequential courses in the student's professional choice should be offered that will equip the student with additional skills and departure points.

1.2 Spinoffs into specific career choices may be offered at the upper level of the second year depending on specific areas chosen by student and evaluation of potential success and performance of applicants.

1.3 Extensive counseling including tutoring programs and flexibility in course load for students will be available as needed.

C. Third Year

1) More advanced curriculum for the specific career choice. Continual interdisciplinary collaboration must be maintained throughout the educational experience to prevent polarization and professional isolation.

1.1 In-depth educational exposure for the specific professional major (nursing, medicine, administration, etc.)

1.2 Extensive counseling, including tutoring programs and flexibility in course load.

D. Fourth Year

1) Deep analytic approach to career choice. Specific attention given to provocative health issues. Interdisciplinary collaboration continually permeating educational experience.

1.1 Courses which allow for developing processes and patterns that are useable, common between teacher - student, disciplines, schools, service facilities, providers - consumers, communities - institutions.

This fourth level is where the writer is attempting to develop students in community assessment and analysis. The course in community health operates from the conceptual framework that has previously been presented; final refinement of this curriculum module will be available in a few months.

E. Additional. The curriculum continues until the student reaches the desired level of his career choice.

Respectfully submitted,

Roberta Watts*

*Ms. Watts left the Institute early because of illness at home, but completed this curriculum design for Health Service Practitioners.

A Model for a Continuing Education Faculty Workshop on Inner City Ambulatory Health Centers

Goal:

To improve the health and health care of inner city residents.

Objectives:

1) To improve the administration of health care centers.
2) To assist in the establishment of additional health care centers.

Achieving Goals and Objectives:

1) Introduce faculty members in appropriate fields to health care centers.
2) Introduce and sensitize faculty members in appropriate fields to inner city health problems and related problems.
3) Introduce faculty members in appropriate fields to the skills needed to establish and/or administer health care centers.

So the Faculty Members May:

1) Help establish degree and/or non-degree programs and/or course and/or modules and/or class sessions in the establishment, administration and/or problems of health care centers.
2) Do research, consulting, and/or community service in health care centers.
3) Present to students the needs and opportunities in health care centers.
4) Encourage, direct and/or recruit students and graduates to work in health care centers.
5) Acquaint their faculty colleagues with needs and opportunities in health care centers.

Workshop Methodology:

1) Lectures.
2) Seminar discussions.
3) Reading assignments.
4) Panel discussions by practitioners.
5) Movies and other audiovisual aids.
6) A written assignment on a team or individual basis.
7) Field trips.
8) Field assignment to two or more health care centers and one health care center network headquarters.

Course Outline:

I. Introduction.
II. Backgrounds.
III. The functions of health care center.
IV. Problems of health care centers.
V. The association of health care centers.
VI. Health care center networks.
VII. Health maintenance organizations (HMO's).
VIII. Grant writing and reporting.
IX. Conclusion.

Course Calendar: (Three week workshop)

Sunday: 5:00-7:00 P.M. Registration.
8:00 P.M. Tour of campus.

Monday: 9:00 A.M.-Noon Introduction. Structuring of Workshop.
1:00-2:30 P.M. "Social Problems Impinging on Health Care Centers."
2:30-4:00 P.M. "The Economics of Poverty".

Tuesday: 9:00-10:30 A.M. "The History of Consumerism in Health Care".
10:30 A.M.-Noon "The History of Health Care Centers in the U.S.A.".
1:00-4:00 P.M. "Community Diagnosis".
6:30-8:00 P.M. Reception.

Wednesday: 9:00 A.M.-4:00 P.M. Field experience.

Thursday: 9:00 A.M.-4:00 P.M. Field experience.

Course Calendar (continued)

Friday: 9:00-10:30 A.M. "DHEW Presentation of Their Expectations of Health Care Centers".
10:30 A.M.-Noon "Financing of Health Care Centers".
1:00-3:00 P.M. "Functions of a Health Center - Outreach".
3:00-4:00 P.M. Students discuss their field experiences.

Saturday: Open.

Sunday: Open.

Monday: 9:00 A.M.-Noon "Functions of a Health Center - Nutrition".
1:00-4:00 P.M. "Functions of a Health Center - Prevention".

Tuesday: 9:00 A.M.-4:00 P.M. Field experience.
6:30-9:00 P.M. Picnic.

Wednesday: 9:00 A.M.-4:00 P.M. Field experience.

Thursday: 9:00 A.M.-Noon "Functions of a Health Center - Screening and Risk Factor Analysis".
1:00-3:00 P.M. "Functions of a Health Center - Creating Neighborhood Awareness".
3:00-4:00 P.M. Students discuss their field experiences.

Friday: 9:00 A.M.-Noon "Functions of a Health Center - On-The-Job Training. Community Leadership Training".
1:00-4:00 P.M. "Functions of a Health Center - Treatment of Physical and Mental Illness".

Saturday: Open.

Sunday: Open.

Monday: 9:00A.M.-4:00 P.M. Field experience.

Course Calendar (continued)

Tuesday:	9:00 A.M.-4:00 P.M. Field experience. 6:30-8:00 P.M. Social Get-Together.
Wednesday:	9:00 A.M.-Noon "Common Problems of Health Care Centers - A Panel Discussion". 1:00-2:00 P.M. "The Association of Health Care Centers". 2:00-3:00 P.M. "Health Care Center Networks". 3:00-4:00 P.M. Students discuss their field experiences.
Thursday:	9:00 A.M.-Noon "HMO's". 1:00-4:00 P.M. "Grant Writing and Reporting". 6:30-8:00 P.M. Final Reception.
Friday:	9:00 A.M.-Noon Student presentations of their written projects. 1:00-4:00 P.M. Student presentations of their written projects.

Comments on Workshop Methodology:

1) Lectures to be held in a place that will lead to improved interchange between lecturer and student. Lectures to be taped.

2) Following each field experience there will be a discussion correlating the objectives of that day's field experience with the next day's field experience and discussing important events observed.

3) Guest lecturers to provide recommended readings well in advance and correlate readings with their presentation.

4) Panel discussions to bring together local/community health center administrators and workers to discuss common problems and their view of the total health care system.

5) Field trips to health centers with specific observation objectives in mind.

Comments on Field Experience:

Students to be assigned to two differing types of centers and one network headquarters office.

The project assigned the student at the center or centers will have meaningful educational content as well as being a service to the center.

The administrators of the centers are to attend an orientation session concerning the workshop, its objectives, and the objectives of the field experience before the workshop starts.

There should be a pre- and a post-conference held before and after each student's field experience (attended by the student, the center administrator, and a staff member of the workshop) for orientation and evaluation purposes.

There should be an identifiable preceptor in each center responsible for the student's field experience.

A workshop staff member should visit each field experience.

Respectfully submitted,

Leslie Anderson
Lois Nelson
Julia Spight
George Wren

A Bibliography on Neighborhood Health Centers

by Ann Zwertschek, M.S.

Anderson, Donna M., and Markay, Kerr. "Citizen Influence in Health Service Programs." American Journal of Public Health, 61:518-523, August, 1971.

This article is an exploratory study of citizen participation in decision-making in the delivery of health services. The authors attempt to answer three questions: 1) Do consumers of health services actually participate in decision-making? 2) What is the nature of this participation and 3) What is the relationship of certain external factors to the nature of participation? This study showed that certain factors, independent of interaction and content, affect participation. Citizen participation is viewed as a process. Based on an opinion poll, the researchers concluded that there was much disagreement between providers and consumers about where the responsibility for determining what services should be offered, final approval for hiring, and who should gather information about health problems.

Baehr, George. "Some Popular Delusions about Health and Medical Care." American Journal of Public Health, 61:582-585, March, 1971.

The author attempts to dispel some current delusions concerning the provision and improvement of medical care. He offers a program for a more effective and more economical payment for health care. He encourages the enrollment of families in neighborhood Family Health Maintenance Centers, monthly capitations, and prepayments instead of fee-for-service. He suggests that the health departments should monitor quality and cost of the centers, reduce hospital utilization, and reduce wasteful duplication of physicians' services. If effectively planned, and oriented, these centers can be the model for the nation and point the way to legislative provisions in the future formulation of national health programs.

Bellin, Seymour, S., and Geiger, H. Jack. "The Impact of a Neighborhood Health Center on Patients' Behavior and Attitudes Relation to Health Care: A Study of a Low Income Housing Project." Medical Care, 10:244-239, May-June, 1972.

A previous paper, based on clinic records, showed high levels of utilization of health center services by low income community, approximating comparable figures for a more affluent population. A great majority of community residents, based on a before-after health survey of a random sample of households, currently report the health center as their regular source of health care. Residents make extensive use of not only curative services but also of preventive medical services, e.g. asymptomatic checkups and immunizations. The main focus here is to seek to account for such changes in health behaviors and utilization in terms of two sets of possible explanatory factors: attitudes and circumstances. Attitudes are examined towards health, health care, and sources of such care. In addition, consideration is given to the possible role of several situational factors--time, money, and convenience--in influencing patterns of utilization. Significant changes are reported in all attitudes, paralleling changes in utilization of services. A marked decrease also is reported in such potential barriers to use of services as expenditure of time and money. Inferences are drawn about the implication of these findings for health service planning.

Bergner, Lawrence, and Yerby, Alonzo S. "Low Income and Barriers to Use of Health Services." New England Journal of Medicine, 278:541-546, March 6, 1968.

The authors contend that the poor in the U.S. receive a disproportionately low share of health services. The barrier of direct cost is not sufficient to explain this underuse, and the advent of Medicare and Medicaid will not erase the existing discrepancies. The data show that the failure to inform adequately potential clients of the existence and availability of services is a significant barrier. The organization, administration, and conduct of services can be important deterrents to use. The professional health worker should be trained to be able to provide effectively his services in comprehensive programs for the poor and the uneducated.

Blendon, Robert J., and Gaus, Clifton R. "Problems in Developing Health Services in Poverty Areas: The Johns Hopkins Experience." Journal of Medical Education, 46:477-484, June, 1971.

Since HEW has encouraged established medical institutions to develop new health services for low income populations, the Johns Hopkins Medical Institutions decided to undertake such a program. This paper describes the extraordinary difficulties they encountered. The most annoying situation was the frag-

mentation of governmental programs which made it difficult to undertake the program. In addition, they faced the problems of finding an unusually skilled staff and of providing a great deal of financial support. The lack of definitive roles for community participation also added to their problems.

Brieland, Donald. "Community Advisory Boards and Maximum Feasible Participation." American Journal of Public Health, 61:292-296, February, 1971.

The purpose of this article was to examine whether maximum feasible participation (MFP) in community action programs such as health can be accomplished, and if so, what principles are involved.

The author points to the danger of co-optation because it can be a means of buying-off and pacifying militant leadership by giving them status in an official advisory board. MFP can be a mere rhetorical flourish and serve to assimilate and divide radical elements. Democratic selection of representatives is not always recommended because there could be a problem of participation and a take-over by a specialized group. The representativeness presents a difficult problem because the person selected is obviously both available and responsive and these do not always go along with representativeness.

The author contends that there is a need for leadership development so that the base for participation can be enlarged and the board can gain specialized knowledge. Advisory boards in health projects are seen as a means of involving the community in activities for its own best interest. The board should concern itself with matters that affect its geographic area; it should not insist on illegal policies; and it should be able to bring complaints concerning program policies to city officials. The author also recommends that there be rotation of board membership, and to insure participation, payment of transportation and babysitting fees.

This article is somewhat unclear and vague, like the original OEO guidelines. Mr. Brieland never seems to come to grips with what is considered feasible or the differences between feasible and desirable.

Bryant, Thomas. "Goals and Potentials of the Neighborhood Health Center." Editorial in Medical Care, 8:94-95, March-April, 1970.

This editorial introduces a series of articles on neigh-

borhood health centers written from different perspectives. The writer sees the neighborhood health center as a health institution, a social institution, a training and employment agency, a financial mechanism, and a political institution. Most importantly, he thinks the N.H.C. reflects the population and environment it serves.

Articles included in this issue:

Kalunzy, Arnold, and Levine, Sol. "The Social Scientist's View of the Neighborhood Health Center as a New Social Institution."

Elinson, Jack, and Herr, E.A. Conrad. "A Sociomedical View of Neighborhood Health Centers."

Fein, Rashi. "An Economist's View of the Neighborhood Health Center as a New Social Institution."

Feingold, Eugene. "A Political Scientist's View of the Neighborhood Health Center as a New Social Institution."

Schaeffer, Morris. "Commentary on the Social Scientists' View of the Neighborhood Health Center as a New Social Institution."

Bullough, Bonnie and Bullough, Vern L. Poverty, Ethnic Identity, and Health Care. New York: Meredith Corporation, 1972.

This book is a very basic approach to the problems faced by minority communities concerning health. They point out the relationship between poverty and poor health. The authors contend that this vicious cycle must be broken before there can be progress. Their analysis of the various ethnic groups seemed to contain some stereotype descriptions.

Campbell, John. "Working Relationships Between Providers and Consumers in a Neighborhood Health Center." American Journal of Public Health, 61:97-107, January, 1971.

This study raises several relevant and important questions about consumer participation. Through an analysis of the experiences of the Hough-Norwood Health Center, Cleveland, Ohio, the author attempts to answer these questions and propose some solutions to the problem.

Are advisory roles for consumers adequate? No, if the

consumers are confined to advisory roles and their inputs are dependent upon the provider to accept or reject them. Advisory roles not only frustrate the political and psychological needs of consumers but can isolate them from awareness of the complete spectrum of issues and problems involved in the delivery and use of health care. The answer to the question of consumer involvement in policy formation is "yes" because policy is the name of the game of power.

Both consumers and providers can learn, grow, and develop through real involvement with each other in the discussion-decision process.

Neighborhood health centers, by their very nature, are destined to have problems. However, far greater problems appear to be posed unless the programs are designed so as to reverse the historical lack of participation by poor consumers in controlling their own destinies. To resolve the issues of conflict in such a way as to provide learning experiences for both parties, and to retain or develop community support, effective relationships between consumers and providers are required.

Campbell concludes that those who are working for effective consumer-provider relationships must seek methods which have broad applicability in this vital area of human relations.

Caton, Myrtle V. "Problems of Neighborhood Health Center Employees in Watts." American Journal of Public Health, 61:814-819, April, 1971.

This article describes the health problems of the employees in an OEO neighborhood health center in Watts. The important point is that many indigenous employees in health centers do not have optimum health status themselves. The "new" employee is more likely a person who has been denied health care in the past. A job is not enough. The author contends that in order for indigenous employees to have gainful employment, it is necessary for the health professionals to provide comprehensive maintenance.

Cervantes, Robert A. "The Failure of Comprehensive Health Services to Serve the Urban Chicano." Health Services Report, 87:932-940, December, 1972.

This article was written to point out why the existing health programs do not help the urban Chicanos. Cervantes cites an anglo-middle-class syndrome, lack of empathy and a

tendency to stereotype as major reasons. Lack of adequate literature and research about the Chicano and the acceptance of the "folk-culture syndrome" by Jaco and other researchers only contribute to false perceptions of the Chicano. Existing programs are ineffective because their rationale is at variance with the structure of the Chicano social and community organizations and their meaning is not defined with Chicano perspectives in mind. As a solution to the problem, the author suggests recruitment of Chicanos in the health professions, incorporation of cultural, linguistic and ethnic elements in the programs, paid Chicano consultants to be used in the planning and delivery of services and research conducted by Chicanos. To continue the existing programs only perpetuates the problem, invites controversy and widens the credibility gap.

Chapman, Larry S. "The Neighborhood Health Center Foundation for Health Care: A Portend for the Future or a Necessity for Survival?" American Journal of Public Health, 63:841-845, October, 1973.

The purpose of this article is to emphasize that recent changes in federal health service funding policies demand an increasing emphasis on cost-effective management and increased revenue generation activities. Chapman suggests there needs to be a more dynamic and innovative approach to problem solving. He proposes a Foundation as a model to solve some of the problem of fragmentation of support, lack of expertise and experience. In the model proposed there would be a board made up of consumers, providers and an advisory board consisting of representatives from the individual health centers. The benefits of this system would be more stable provider relationships due to better general and financial management, and a greater scope of services could be offered due to effective use of financial and manpower resources. Technical assistance could be offered to the individual neighborhood health centers and their specific problems could be analyzed on the basis of experiences other centers have had.

Of course the disadvantage of such a system would be a loss of a certain amount of local autonomy and parochial concerns, but on the other hand, it would be better to sacrifice these elements than to lose the whole movement.

Chapman concludes that although it will be difficult to accept, a Foundation is needed to help the individual neighborhood health centers become more effective.

Chisholm, Shirley. "Community Health and Community Participation." Bulletin of the New York Academy of Medicine, 46:11144-1148, December, 1970.

Shirley Chisholm states that it is important for every professional involved in providing services to understand that it is no longer an issue whether the community can or cannot, or should or should not, or even will or will not participate in the planning and implementation of the services to itself. The issue now before us is: How can the community best participate in the planning and implementation of the delivery services that most crucially and directly affect its life and well-being.

Coleman, Arthur. "Health Care Politics at the Community Level." In Politics of Health, edited by Douglas Cater and Philip R. Lee. New York: Medicom, 1972.

Dr. Coleman says that the major political questions focus on the decisions and who makes them. Until recently most minority communities were weak, but now the situation has changed. He concludes that the revolutions in the health field, taking place at the community level, as well as the national level, are responses to new demands for health care services at the community level. Dr. Coleman discusses who are the adversaries of minority communities in the health services arena.

"Community Participation for Equity and Excellence in Health Care." 1970 Health Conference. Bulletin of the New York Academy of Medicine, December, 1970.

The 1970 Health Conference focused on Community Participation for Equity and Excellence in Health Care. The speeches and discussions cover the different perspectives and aspects of community participation, national health policies, and the role of the health professionals in achieving effective consumer participation. This issue is a good resource for discussion.

Conant, Ralph. The Politics of Community Health. Washington, D.C.: Public Affairs Press, 1966.

The pamphlet examines the road blocks to and the problems in planning and establishing health facilities. Of particular interest is the chapter on Cincinnati. It gives a thumbnail sketch of the character and political background of the city and the politics involved in the city's health problem.

Creditor, Morton. "The Neighborhood Health Center. Where does the Hospital Fit?" American Journal of Public Health, 61:807-813, April, 1971.

This paper presents the experience of a large teaching hospital in its attempt to develop a neighborhood health center. This involved the development of a facility for ambulatory care by and for a community which is largely black. The author makes the point that the institutional naivete contributed to the initial problems. To the hospital's surprise, it was confronted with a community which was not so sure it wanted the hospital in the community. The community questioned the hospital's right to intiate the program. The most shattering blow was that the community frequently made statements of dissatisfaction with the type of services that the hospital was providing. The author recommends community control and ownership with a caution against isolation from the mainstream of health care, and encourages insertion of such facilities, as he describes them, as co-equal components in evolving systems of care.

Daniels, Robert S. "Governance and Administration of Human Services in Urban Low-Income Communities." American Journal of Public Health, 63:715-720, August, 1972.

This paper focused on three areas: 1) the experiences of the University of Chicago Pritzker School of Medicine with advisory boards and boards of directors, 2) the structure and function of such boards and reactions of professionals and institutions to them and 3) suggestions of certain developments which might take place in reference to community governance groups. From the very beginning there was a power and authority struggle between the University of Chicago and the community because of the unclear role of an advisory board. The community had little or no training and had complex and unreal expectations. The advisory board members had diverse points of view and rarely stood together. The institutions and professionals were not accustomed to consulting local people about planning for service or about operations of that service. There was no clear definition of function or authority. As a result of these early experiences, the university and the community formed a non-profit group with a board of directors, composed of community, and institutional representatives. This seems to have been more successful and a good solution to the problem. From this analysis of the present situation, the author has compiled a list of principles which emphasizes community ownership and authority through a structure often employed in other human service systems, the board of directors.

Dr. Daniel's analysis is very clear and he does offer a realistic and viable solution. His list of principles could be very helpful to health planners in their preliminary stages of planning. There is no excuse for repeating past mistakes, and a careful reading of Daniel's suggestions can possibly prevent this.

deDiaz, Sharon Daniel. "Beyond Rhetoric--The NENA Health Center After One Year." American Journal of Public Health, 62:64-68, January, 1972.

An account is presented of a center for the provision of ambulatory medical care on the New York Lower East Side. This consumer presentation bears on questions of developing more national health care systems on a local, regional or national basis as well as models for consumer participation in health policy.

Elinson, Jack and Herr, E.A. Conrad. "A Sociomedical View of Neighborhood Health Centers." Medical Care, 8:97-103, March-April, 1970.

This study attempts to make more explicit some of the latent, manifest and not-so-manifest functions of the neighborhood health center. The authors contend that one latent function was to improve the image of the black male and provide male models. The boards therefore, contained more than fifty percent men, because the women would have dominated if the distribution had been equal. The neighborhood health centers have stimulated and maintained solidarity among the community members through their participation on advisory boards and having a part in decision-making. The health centers are used as a means of pacifying hostile communities, by colonial powers. (See Mt. Sinai or Temple University experiences as examples of this.) The neighborhood health centers function as a way to discharge the missionary service obligation of the medical and hospital establishments. They employ indigenous personnel to prepare them to eventually govern themselves. The authors believe that the neighborhood health centers fill a political void in social and economic action. Elinson et al. conclude that whether they are government controlled or not, the neighborhood health center operates in a broader social and political area than just health. They are a legitimate and politically aceptable conduit for funds to be used beyond the mere provision of health services.

This article gives a good analysis of the functions that are ordinarily not recognized when one looks at an application

for a grant or the by-laws of a neighborhood health center constitution. The authors seem to imply that certain changes and methods will be acceptable under the facade of health.

Elling, Ray H., and Lee, Ollie J. "Formal Connections of Community Leadership to the Health System." Milbank Memorial Fund Quarterly, 44:294-306, July, 1966.

This paper discussed some forms of leadership involvement in health planning bodies and other organizations of the health system in a metropolitan community. Some aspects of leadership discussed are: 1) What are social characteristics of top community influentials 2) What types of leaders have the most connections to the health system and 3) What types of leaders have broad connections with various kinds of health agencies.

Freeman, Howard E.; Levine, Sol; and Reeder, Leo. Handbook of Medical Sociology. Englewoods, New Jersey: Prentice Hall, 1972.

In the introduction to this second edition, John H. Knowles defines its purpose: to enlarge the understanding of a health professional about himself and the professional socio-economic system in which he works, and to better understand the objects of his professional works. Of particular interest to the health professional is part III--Sociology of Medical Care. The essay "Public Health in the Community" is very helpful.

Freeman, Howard E. and Lambert, Jr. Camille. "The Influence of Community Groups on Health Matters." Human Organization, 4:353-357, October, 1965.

The purpose of this study was to determine what influence voluntary associations have on health matters. The study group was composed of 298 lower-income families with at least one child, five-eight years old, at least one breadwinner and at least three years of residence in the community, Brookline, Mass.

The participants were given a list of twelve organizations and asked whose advice would they most and least likely follow. The findings revealed that membership in a voluntary association does not always mean that an individual will accept that association's advice in matters of health. In fact the net influence, (most-least/most+least), of most voluntary associa-

tions is negative.

Freeman et al. conclude that on one hand it is defensible to use voluntary groups in community health programs if the sanction of the leadership is needed to launch the program. But, if participation is rationalized on the basis of encouraging grass roots rather than group sanction, and if the influence on a net basis is negative, the outcome may suffer. In fact, if the views of the association are a negative influence, efforts to alienate the association should be taken, rather than to attract it. Health planners are cautioned to take this into consideration before they decide to involve voluntary associations in their programs.

The researchers do have a scientific and rational approach to a serious problem. They caution health planners to do some investigation before they open a can of worms that could have remained closed.

Gordis, Leon, M.D., Dr. P.H. "Effectiveness of Comprehensive-Care Programs in Preventing Rheumatic Fever." The New England Journal of Medicine, 7:331-335, August, 1973.

Four inner-city comprehensive-care programs in Baltimore were evaluated by study of their effect on incidence of rheumatic fever. Annual incidence of hospitalized first attacks was estimated for the black population five to fourteen years old living in census tracts eligible for these programs in 1968-70. For comparison, incidence rates in three noneligible population groupings were calculated and compared with rates for 1960-64, before these programs were established.

The rate of rheumatic fever for comprehensive-care tracts in 1968-70 was about one-third lower than for the rest of Baltimore. From 1960-64 to 1968-70 rheumatic fever decreased sixty percent in comprehensive care tracts but was unchanged in the rest of the city. The findings thus suggest that comprehensive-care programs have been the critical factor in reducing the incidence of rheumatic fever in the inner-city.

Hatch, John, W. "Discussion of the 'How' of Community Participation in Delivering Health Care." Bulletin of the New York Academy of Medicine, 46:1084-1091, December, 1970.

This article describes the gradual procedure of contact with a community and their eventual participation. The author initially spent four months working and living in the community before the program was undertaken. He found that the behavior

of the community varied greatly, and depended on with whom they were in contact, black or white. The target area was Bolivar County, Miss., a predominantly Black and poor area. It was determined that health was not a high priority for the people of the community. Food--lack of it--was the highest priority, so that the first program set up was aimed at solving some of the malnutrition. Cooperatives were formed and gradually the community became supportive. The health center board was organized on the model of the Baptist Church Council, the only real organization with which the community had any contact.

Mr. Hatch cites several principles, which he recommends considering before launching a full-blown project. The professionals should become attuned to the cultural life and priorities of the community. The unobservable strengths of the community should be determined. Since community views outside intervention with suspicion, there should be an integration of the health professionals before the program is launched. Lastly, he thinks that a service agency, such as a health center, can play a catalytic role in the development of resources for basic social and economic changes.

Hillman, Bruce and Evan Charney. "A Neighborhood Health Center: What the Patients Know and Think of Its Operation." Medical Care, 10:336-344, July-August, 1972.

This study assessed how an OEO neighborhood health center was perceived by its registered clientele. The health center provided comprehensive ambulatory and hospital services 8:30 a.m. to 9:30 p.m., and a twenty-four hour on-call service. Each family had its own private physician, team nurse and health worker, who was a patient advocate. Interviews from a sample population of 9,000 registered families provided the data.

Questions were asked to determine how well registered patients know and understand the roles of the providers and the services of their health center and what they like or dislike about the program. The findings showed that ninety-three percent considered the access convenvient and the programs good and seventy percent knew of the twenty-four hour on-call physician services. There was no correlation between name knowledge and satisfaction. There were no negative feelings about the nurses and the healthworkers and all uniformly rated the physician high. Sixty-three percent were satisfied for no special reason; fifteen percent liked an individual; and fifteen percent cited physician concern as a reason for their liking the programs. Seventy-three percent didn't know who controlled the center; forty-four percent didn't care who

controlled the center, thirty-seven percent thought those in charge should run it and nine percent thought the community should run it. Based on these data, the authors conclude that the urban health center has been accepted enthusiastically by the urban poor, and community control is secondary to quality and empathy of care.

Hoff, Wilbur. "Why Health Programs Are Not Reaching the Unresponsive in Our Communities." Public Health Reports, 81:654-658, July, 1966.

This article analyses the reasons why the lower socio-economic class are unresponsive to health programs. Socio-economic studies have shown that social class, income, race and education are related to sickness and disease. The data show that hard-to-reach people usually come from the lower income brackets and from families with many problems. Priority of basic needs over health needs is an important factor to low utilization. Negative attitudes held by health workers create a communication gap. Rigid programming, failure to adapt to the needs of the community and programs based on middle class preferences make irrelevant and inflexible programs.

Hoff suggests several ways to increase contacts with this unresponsive group. Health education should be conducted in localities familiar to them. Auxiliary health workers from the community should be recruited. Also, it is suggested that health workers be given in-service sensitivity training in the values and belief system of this unresponsive group.

Howard, Lawrence, C. "Decentralization and Citizen Participation In Health Services." Public Administration Review, 33:701-717, October, 1972.

This essay asks one central question: "Why is citizen participation important to health?" Section I of the essay focuses on how consumer participation adds the care of people for each other to professionally offered medical services. Section II describes the comprehensive neighborhood health center, where community participation is a central concern. Section III introduces the idea of a health base for health care. The final section examines the role of the public affairs profession in an emerging medical health service field in which political concerns have become prominent. Howard concludes that participation is important because health is an active pursuit of collective human destiny.

Jonas, Steven. "Theoretical Approach to the Question of Community Control of Health Services Facilities." American Journal of Public Health, 61:916-921, May, 1971.

This article examined three questions: 1) Is community control as defined by its advocates a meaningful concept, that is, can it exist and produce achievements? 2) Is the struggle for community control productive? 3) What positive roles might professionals play in community control struggles?

The author defines community control as the method by which health services institutions will become publicly accountable and accessible, and by which medical services, consistent with individual and patient's rights and full rights for all, will be produced.

The struggle is significant if the people running the agency are changed from those chosen by some external agency to those chosen by a community board, and if this board is given authority to determine spending priorities with a fixed budget. Dr. Jonas sees administrators as essentially powerless and he thinks the struggle should be directed toward the real power holder, the state, which controls capital budget, expense budget and supply of staff. Professionals can help in the struggle as both members and leaders and in an advisory capacity. When community participation is carried on in an atmosphere of mutual cooperation, certain improvements can occur. Involvement can provide community people with an excellent understanding of where power really does lie and can provide professionals the opportunity to work with the community instead of against them. In summary, he concludes that an alliance between these two groups would be the most effective and productive way to gain real control.

Li, Fredrick, P.; Schlief, Nyuk; Chang, Caroline J; and Gaw, Albert O. "Health Care for the Chinese Community in Boston." American Journal of Public Health, 62:536-539, April, 1974.

This article described the introduction of neighborhood health care for the Chinese community in Boston. The authors give the background of the Chinese immigration, occupational patterns and traditions. The usual problems of being poor and sick were compounded by the language and cultural barriers to medical care.

The Chinese Community Health Projects Task Force was formed to involve individuals and agencies in the Chinese

health problems. No ethnic restrictions were put on membership on the Task Force and this proved a valuable asset. The Task Force attempted to use available resources to launch a pilot health evaluation. This house to house survey, done in collaboration with the New England Medical Center and the Boston Health Department, helped to clarify needs and increase awareness and responsiveness of health agencies. A neighborhood health center was established which was designed to meet the specific needs of the Chinese community. The authors hope that the Chinese experiences can serve as a model for minority groups seeking better health care.

The Chinese experiences are very interesting because the establishment of health care was accomplished with more or less no violence and within the existing system.

Lindaman, Francis C. "The Voice of the Community." American Journal of Public Health, 62:1245-1248, September, 1972.

The "Voice of the Community" refers to a series of Institutes developed by the Continuing Education Department of Columbia University School of Public Health and Administrative Medicine. As described in the article, the committee selected a community which had a health problem and tailored seminars to meet its particular needs. The goal of the seminars was to improve health care, to see what could be done after the group studied socio-political aspects of the community's life. The seminars were sometimes the first real communication between people in the neighborhood and the professionals.

It was demonstrated that (1) it is necessary to involve community groups and individuals even before it is known whether or not a training program can be funded; (2) relations with the community are strongly affected by interpersonal relations among staff; (3) relations with consumers can only be improved when providers understand one another's needs and gain mutual respect; and (4) the minority group members felt that very few white workers know even the elementary things about minority groups.

Lindaman, Francis C. "Staff Training and the Working Relationships of Providers and Consumers in Spanish Harlem." American Journal of Public Health, 60:1225-1229, July, 1970.

This article describes a demonstration project undertaken to improve working relationships between health workers and the community. A seminar approach was used. One positive result was more friendliness among workers and community residents.

The project was so successful that it was recommended that it become a part of the regular activities and funds were made available for two more similar projects. They also concluded that sensitivity training must go hand-in-hand with technical training if the worker is to be effective in today's complex and rapidly changing society.

Milio, Nancy. 9226 Kercheval--The Storefront That Did Not Burn, Ann Arbor: University of Michigan Press, 1970.

This book is the story of a venture into the black ghetto of Detroit, of the development of a ghetto health project, which still exists today, told from the inside by a white outsider who was present. The author confesses her initial naiveté about the politics of living, the use of power, the force of vested interests and the efficiency of the "helping professions." The original project, the Maternal Satellite Center, was sponsored by the Visiting Nurses Association. The change of the name to the "Moms and Tots Center", marked the first change from a white-run institution to a community oriented project. Miss Milio describes some of the ups and downs involved in the development of the health center and the ideological and communication problems she had. The center did survive the fires of the 1967 Riots and Miss Milio credits this to the fact that the community perceived it to be responsive to their needs. She points out that, as an administrator, she learned that it was dangerous to encourage people to talk because the person in charge cannot predict what will happen. But this dynamic process is essential if the health center is going to be a community-oriented project. Eventually the Moms and Tots Center became totally community run and this was due to the author's sensitive perception of the importance of the ghetto population and their needs.

Moody, Philip M., and Gray, Robert M. "Social Class, Social Integration, and the Use of Preventive Health Services." Address presented at the Annual Meeting of the American Sociological Association, August, 1968. Also appears in Physicians, Patients and Illness, Edited by, Jaco, Free Press, 1972.

The purpose of this paper is to present further information on why persons in the lower socio-economic class utilize available preventive health services less frequently than do persons in higher social classes. The authors present a survey of relevant literature. Their own hypothesis is that social integration, defined as a low level of alienation and a high degree of social participation, may account for the

different utilization. The authors suggest that health personnel must be educated concerning the effects of bureaucracy in medicine upon some lower-class clients who are alienated and not integrated into community life. It might be more effective to alter perceptions and behavior of health personnel and the system of the delivery of health care, than altering those of the clientele.

Morehead, Mildred. "Evaluating Quality of Medical Care in the Neighborhood Health Center Program of the Office of Economic Opportunity." Medical Care, 8:118-131, March-April, 1970.

Twenty-four OEO neighborhood health centers have been audited to determine the extent to which selected criteria were met in the fields of adult medicine, infant care, and obstetrical care. Principles of group operation, sample selection, the scoring process and results are presented. The centers were ranked by their scores and various characteristics. Program design, patient volume, medical school affiliation, and most important administrative "know-how" were concluded to be major factors associated with high performance ratings. Audits of the professional judgements which were used in clinical management in six major specialty fields and dental care, underway at the present time, are described. Although comparable datum is not available from other settings, it is believed that the majority of centers are performing at satisfactory levels.

Morehead, Mildred A.; Donaldson, Rose S.; Seravelli, Mary R. "Comparison Between OEO Neighborhood Health Centers and Other Health Care Providers of Ratings of Quality of Health Care." American Journal of Public Health, 61:1294-1306, June, 1971.

This study compared the quality of health care provided by thirty-five OEO Neighborhood Health Centers, ten medical school OP departments, and twenty-two nonhospital providers, which included three rural solo practitioners and nineteen group practices. A total of 3,040 patients were involved. A rating scale, based on a medical school OP department taken as the standard, was used and a score was arrived at: (expectation met/expected care).

OEO neighborhood health centers and group practice plans had higher ratings in patient histories, adult medical assessments, immunizations and rapidity of services after initial contact. The OP department had higher ratings in the fields of pediatrics and obstetrical care. The solo practitioner had the lowest overall ratings, the greatest dis-

crepancies being in adequate history, medical assessments and immunizations. The researchers conclude that the OEO neighborhood health center is performing at a credible level. Areas where improvement is needed are in obstetrical and pediatric care.

The value of this study is that it dispels rumors that the OEO neighborhood health centers are delivering second class care. There are implications that the once "hallowed" medical school OP departments and the sacred solo practitioner need some improvement in their delivery of health care and could take some pointers from the OEO centers.

Moore, Mary L. "The Role of Hostility and Militancy in Indigenous Community Health Advisory Groups." American Journal of Public Health, 61:922-930, May, 1971.

This study attempted to deal with the lower class group as an operational unit in its natural setting, and to examine some of the complex and countervailing forces which prevail, by means of participant observation of behavior of such population groups as community advisory boards.

Researchers become bonafide members of five advisory boards, four of them composed of eighty-five percent indigent members, and the fifth board of eighty-five percent professional members. They used participant observation techniques to obtain accurate portrayal of themes and development. Those characterized as poor, displayed sixteen to eight episodes of hostility in the first encounter. Professionals frequently resorted to traditional group control methods of negative reinforcement techniques, such as changing rooms or serving coffee. In groups I-III, control measures were effective and hostile episodes decreased. Group IV, considered by the professionals as the most uncooperative and impractical, was the most functionally effective group and it tended to make decisions on subjects sacred to health professionals. Group V was a rubber stamp mechanism and ineffective. Observations indicate that militant demands brought results and increased group cohesiveness. Implications of this study are that purposive control of hostile and militant behavior produces a non-functional less cohesive advisory group. Health professionals should attempt to gain, as objectively as possible, understanding of the necessity of hostility and militancy and their roles in group behavior.

The results of this study pose an interesting problem for health professionals. Whether an advisory board is

effective or not, it can sometimes be controlled. The implication is that non-participation is a function of the health professionals action, not of a recalcitrant and unresponsive community.

New, Peter Kong-Ming, and Hessler, Richard M. "Neighborhood Health Centers: Traditional Medical Care at an Outpost?" Inquiry, 9:45-58, December, 1972.

The authors discuss neighborhood health centers and the innovations that have merged with them such as consumer participation, the training of indigent community residents as health workers. Aside from these innovations is health care still approached in the traditional manner? New and Hessler asked consumers and providers the following question: "Are neighborhood health centers just outposts where traditional care is provided?" They conclude that traditional health service providers deal with delivery problems in the traditional way. The participants within the health centers express their hope that the centers will not become yet another traditional health care institution. But since providers and institutions implement the plans of a health center this will be difficult.

Paredes, Americo, and Stekert, Ellen J. "The Urban Experience and Folk Tradition." University of Texas Press, American Folklore Society, 1972.

This article describes the psychological problems created by the mass immigration to urban centers. Their discussion of the Appalachian immigration to Cincinnati is especially interesting. There is a communication gap and anonymity in the health field.

Pozen, Michael W.; Sachs, Eugene I.; Stammer, James L.; and Fish, Frank. "A Family Health Care Center--An Ongoing Student Endeavor." American Journal of Public Health, 62:199-204, February, 1972.

This article describes a Family Health Care Center whose primary goal was to provide an educational venture in community health and output medicine. The health team at the center consisted of senior and junior medical students, nurses and an internist, who was a faculty member. The 524 members of the health center were eighty-six percent Black, eleven percent Puerto Rican, and three percent White. Of these 524 patients, forty-two percent had no pathology, and fifty-eight percent did have pathology. Two-hundred and ten diagnoses were made and included infectious diseases, chronic diseases such as epilepsy, hypertension, peptic ulcers, colitis, anemia, and psychiatric

disorders. A program of quality control was instituted which was a type of peer evaluation done on the basis of a random examination of patient charts. The community acceptance of the program was based on dependability, credibility and continuity of care, which the staff was able to establish.

The value of such a program is that students learn to effectively work as team members and utilize a large variety of services including lawyers, community agencies and social workers. The exposure of the students to family practice and urban medicine would hopefully encourage more students to go into this type of practice rather than some special-part-of-the-body-practice.

Pratt, Lois. "The Relationship of Socioeconomic Status to Health." American Journal of Public Health, 61:281-291, February, 1971.

This study was made to see whether a deficient pattern of personal health care was an important mechanism through which poverty affects health. The data support this proposition. The findings are used to indicate what modifications of behavior might be undertaken; health programs should focus on highly specific health practices found in concentration among low-income women. A multifaceted program of assistance is required, that is, easy access to services and practices.

Rosen, George. "The First Neighborhood Health Center Movement--Its Rise and Fall." American Journal of Public Health, 61:1620-1636, August, 1971.

The purpose of this article was to give the historical background of the neighborhood health center movement and to throw some light on future possibilities of current trends.

The concept of health on a neighborhood basis and the organizational form was a wide-spread movement during the early part of the twentieth century, reaching its peak in the early thirties. The urban population growth, 1860-1910, due to immigration, created neighborhoods or ghettoes of people who had health problems and who were not being reached in the traditional ways.

The N.Y. Milk Plan, Hull House, Henry Street and the Milwaukee Block Plan were some early attempts to meet these needs. The Block Plan even had a center in Cincinnati in the Mohawk-Brighton area, but it was dissolved during the Red Scare. The Red Cross formed some health centers after World War I.

During the twenties a definite coalescence of preventive and curative services leading to comprehensive services could be seen. Many city health departments operated health centers.

The decline came for a variety of reasons--the depression of the thirties, the discovery of antibiotics which were distributed by private physicians. Also the clientele had changed from upwardly mobile immigrants to what we call the urban poor. Political groups and vested interest groups such as the American Medical Association worked for their decline. Dr. Rosen urges health professionals to consider the historical background and the reasons for decline of the first health centers, because although history does not repeat itself, we can learn from it and predict some trends.

Salber, Eva J. "Community Participation in Neighborhood Health Centers." New England Journal of Medicine, 283:515-518, September, 1970.

This article put forth some acceptable and realistic concepts of community participation. The providers of service think the community should advise, but the community thinks it should have more than advisory power. Salber suggests a compromise--a partnership between an informed group of residents and the professionals representing providers who are willing to share power. The community should be given the opportunity to learn the technicalities and language of health and the professionals should shed the jargon and give up the privilege of rank. Lack of exposure to each other has led to unrealistic expectations, hostilities and frustration. The community expects all ills, social and bodily, to be cured by an institution which should be staffed day and night. The staff is idealistic and ignorant of problems and political and financial structure of the community. In order to achieve this partnership and have realistic expectations, Salber suggests a three pronged effort aimed at hospitals and other health institutions, community and staff. There should be maximum exposure to the people and problems and in-service training. For the residents, there should be opportunities to learn organizational structure, jargon and membership on city-wide health committees. Ideally, before a neighborhood health center is planned, this partnership would be formed.

Salber, Eva J.; Feldman, Jacob.; Rosenberg, Lynn A.; and Williams, Shirley. "Utilization of Services at a Neighborhood Health Center." Pediatrics, 47:415-423, February, 1971.

This study assessed the extent of utilization and the

variables affecting it at a neighborhood health center inside a housing project (integrated) in Boston. Interviews of 1,989 children of 521 families, over a period of five months, provided the data.

The authors found that the mean attendance of white children was higher than that of black children. The mean age of the child revealed that the younger the child, the more attention he received and that the older children and adolescents do not receive much attention. AFDC did not affect the utilization nor did the size of the family. There was a reversal of the national statistics: the mothers with lower education levels used the services more.

In addition to these factors, there was a direct association between the number of medical visits and social service agency visits, which led the authors to hypothesize the adverse social conditions are manifested in illness. In examining the results of the study, Salber et al. conclude that more emphasis should be given to the care of older children and adolescents and to remedying the adverse social conditions.

One of the most important findings was the reversal of the national statistics concerning the education level of the mother and the utilization of services.

Shostak, Arthur B., and Gomberg, Wm. Blue-Collar World, Englewood, New Jersey: Prentice Hall, 1964.

This book is a collection of essays about the working class. Of special interest to health professionals are the readings in the chapter "Physical Health and the Community." Attitudes toward health, under-utilization of existing health services, and the psychological environment of the urban worker are analyzed.

Sparer, Gerald, and Johnson, Joyce. "Evaluation of OEO Neighborhood Health Centers." American Journal of Public Health, 931-942. 61:931-942, May, 1971.

This study attempted to evaluate the effectiveness of the OEO neighborhood health center. The researchers examined: who was being reached or not reached; what services are available; the quality, cost and acceptance of these services; changes in use of services; and how various projects compare. Forty-three neighborhood health centers provided the data. The findings show there are new concepts and operational dimensions to primary care. Site appraisal reviews show adequate

provision of comprehensive health services, and this single-service system provides access to full array of primary health care for the family. Baseline surveys and quality reviews show most neighborhood health centers are rated higher than hospital affiliated OP departments, and in general, are better. In continuity with back-up hospitals, thirty-three had formal relations and direct physician responsibility; ten centers had a routine exchange of data and some contact. Cost-wise they compare favorably with other alternatives. The authors conclude, on the whole, neighborhood health centers have been a success at the national level.

Stoeckle, John D., and Candib, Lucy M. "The Neighborhood Health Center--Reform Ideas of Yesterday and Today." New England Journal of Medicine, 280:1385-1391, June 19, 1969.

The early health centers of the 1900s were meant to solve special out-of-hospital health problems of the poor, chiefly infectious disease and infant malnutrition. Preventive measures consisted of immunization and infant feeding. The organizational ideas of centers, district location, community participation, bureaucratic organization and centralization of community health and social services were derived from democratic, religious and industrial ideas common to the era of progressive reform. In actual practice some of the organizational goals were contradictory. For example, whereas such a goal as community participation was important to bring services close to people, simultaneous pressures for efficiency in bureaucratic organization often conflicted. The new health centers, whether traditional or organized as private group practice, have a different and more complex set of health problems requiring social rehabilitation, through personal health services. Although new definitions are being applied to the older organizational ideas, contradictions in dealing with modern problems are also being encountered.

Strange, John, H., Editor. "Citizen Action in Model Cities and CAP Programs: Case Studies and Evaluation." Public Administration Review, 32, September, 1972.

This special issue is devoted entirely to community participation and its effect on public administration. In the introduction, John Strange says that few pieces of domestic legislation have created as much controversy as has the mandate for "maximum feasible participation" of the poor in CAP of the Economic Opportunity and the attempts to insure "widespread citizen participation" in the Model Cities Program. The articles in this issue get to the heart of the controversy and

discuss how public administration is affected by greater participation. The majority of the articles are favorable to citizen participation. Articles include:

"Maximum Feasible Manipulation", as told to Sherry A. Arnstein

"The View from City Hall"

"Citizen Participation in the Philadelphia Model Cities"

"Program: Retrospect and Prospect", Erasmus H. Kloman

"Resident Participation: Political Mobilization or Organizational Co-optation?", David M. Austin

"Power to the People: An Assessment of the Community Action and Model Cities Experience", Robert A. Aleshire

"Reflection on Citizen Participation and the Economic Opportunity Act", Richard W. Boone

"The Impact of Citizen Participation on Public Administration", John H. Strange

Tranquanda, Robert S. and Davis, Milton. "A Sociological Evaluation of the Watts Neighborhood Health Center." Medical Care, 7:105-117, March-April, 1969.

Davis and Tranquada propose that the difference in ultimate objectives and realistic programming have led to many organizational conflicts. This study assesses to what extent this happened in the establishment of a neighborhood health center in Watts. The ultimate goal was to interrupt the cycle of poverty via health programs. The program designers hoped to effect some changes in community cohesion and autonomy. Efforts to involve community residents maximally in decision-making, while the University of Southern California holds the purse strings and the OEO has the final say, have led to several organizational problems. The authors examine what effect different perceptions of reality, a felt need for joint decision-making and/or differentiation of goals have on the realization of objectives. They analyze the situation at Watts in this light.

The authors come to two conclusions, logical and strategic. Logically, in the implementation of a publicly-funded program designed to solve community health problems, it really is not necessary to give a lay community group decision-making power.

Community people should be involved--but as advisors. Strategically, however, if success is important, the question is not whether to involve the community or not, but how to involve the community in a way which provides the local people with autonomy and a sufficiently strong power base that they have the opportunity to control their own destiny. They conclude that the three groups had different experiences, different ideas, and different priorities and only through careful planning and communication could the gap be closed and the conflict minimized.

The Watts Neighborhood Health Center is a classic example of poor organization in which the probability of conflict is high. The best lesson learned is not to repeat the same mistakes. The authors do seem somewhat favorably biased towards the university in their analysis of the conflict.

I. Teaching-Learning Resources (bibliography; updating sources; organization data sources; media)
II. Some Methods for Integrating Information

THE EFFECTS OF PUBLIC POLICY ON HEALTH CARE CONSUMERS
or How Decisions From Up There Affect Choices Down Here

Nancy Milio, R.N., Ph.D.
Boston, April, 1975

I. TEACHING - LEARNING RESOURCES

for faculty and/or student and/or consumer projects in problem analysis, planning, action, and evaluation.

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k) U.S. and International

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l) International

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United Nations Statistical Yearbook.

B. SOURCES FOR CURRENT INFORMATION ON A REGULAR BASIS At Little or No Cost

1) Health Resources News — Health Resources Admin.
Dept. HEW
5600 Fishers Lane
Rockville, Md. 20852

2) Monthly Vital Statistics Report:

3) Vital and Health Statistics Publication Series

(Series 10 "Data from the Health Interview Survey";

" 11 " " " " Examination " ;

" 14 "Data on Health Resources";

" 22 "Data from the National Natality and Mortality Surveys")

Office of Information
National Center for Health Statistics
DHEW, HRA
Rockville, Md. 20852

4) Health Insurance Statistics (Bur. of Health Insurance)

5) Research & Statistics Notes (Office of Research & Statistics)

Social Security Admin.
Publications Staff
1875 Connecticut Ave., N.W.
Washington, D.C. 20009

6) Health Law Newsletter — National Center for Health Law
University of California
National Health Law Program
10995 LeConte, Rm. 640
Los Angeles, CA 90024

7) Legislative Roundup

American Medical Association
535 N. Dearborn
Chicago, Ill. 60610

8) Allied Health Newsletter

Council on Allied Health
Professions, AMA (above)

9) Facts & Analysis - Occupational Health & Safety

Industrial Union Dept.
AFL-CIO Building
815 16th St., N.W.
Washington, D.C. 20006

10) Consumer Survey Handbook Series (re drug prices)

Federal Trade Commission
28th Floor, Federal Bldg.
Seattle, Washington 98174

11) Congressional Hearings and Reports

Write appropriate committee (eg. House Subcomm. on Public Health and Environment; Health Financing Subcommittee; Senate Health Subcomm.; Senate Finance Comm.; Select Committee on Aging; Select Committee on Nutrition & Human Needs).

U.S. Senate
Wash., D.C. 20510

or

U.S. House of Representatives
Wash., D.C. 20515

12) Current Congressional Legislation (designate number, sponsor & title, enclose your mailing label)

Senate Documents Room
U.S. Capitol
Wash., D.C. 20510

or

House Documents Room
U.S. Capitol
Wash., D.C. 20515

C. ORGANIZATION SOURCES FOR SPECIFIC DATA REQUESTS (addresses may be verified in the Handbook of Organizations through your Reference Librarian).

Public Citizen Health Research Group
2000 P St., N.W., Suite 708
Wash., D.C. 20036

Committee for National Health Insurance
806 15th St., N.W.
Washington, D.C. 20005

Health Insurance Institute
277 Park Avenue
New York, N.Y. 10017

Group Health Association of America
1321 14th St., N.W.
Washington, D.C. 20005

National Institute of Environmental Health Sciences
P.O. Box 12233
Research Triangle Park, N.C. 27709

Office of Education, HEW
Bureau of Adult, Vocational and Technical Education
Washington, D.C. 20202

Office of Child Development
Department of Health, Education and Welfare
P.O. Box 1182
Washington, D.C. 20013

Population Reference Bureau
1755 Massachusettes Avenue., N.W.
Washington, D.C. 20036

Walter Reed Army Institute of Research
6825 16th Street, N.W.
Washington, D.C.

Division of Medical Sciences
National Academy of Sciences
National Research Council
2101 Constitution Avenue, N.W.
Washington, D.C. 20418

Library Search Program, Reference Sect.
National Library of Medicine
8600 Rockville Pike
Bethesda, Md., 20014

World Health Organization
Pan American Health Organization
525 23rd St., N.W.
Washington, D.C. 20037

International Planned Parenthood Federation
Information Department
18-20 Lower Regent Street
London, SWIY 4 PW, ENGLAND

Canadian Government
Ministry of Health
Ottawa, Ontario CANADA

British Information Service
845 3rd Avenue
New York, N.Y. 10022

Swedish Information Service
825 3rd Avenue
New York, N.Y. 10022

Some U.S. Organizations Related to Minority Group Issues:

Appalachian Regional Commission
1666 Connecticut Avenue, N.W.
Washington, D.C. 20008

Council of Southern Mountains
(sponsors Appalach. Volunteers)
College Box 2307
Berea, Kentucky

National Welfare Rights Organization
1419 H Street, N.W.
Washington, D.C. 20005

United Farm Workers Organizing Committee
P.O. Box 130
Delano, California 93214

National Conference on Black Women
Box 193
Pittsburgh, Pa. 15230

National Congress of American Indians
1346 Conn., N.W.
Washington, D.C. 20036

Women's Bureau
Wages and Labor Standards Admin., Dept., of Labor
Washington, D.C. 20310

Source For The Following List: National Health Council

American Academy of Family Physicians
Volker Blvd. at Brookside, Kansas City, Missouri 64112

American Academy of Pediatrics
1801 Hinman Avenue, Evanston, Illinois 60201

American Academy of Physicians' Associates
2150 Pennsylvania Ave., Rm. 356, Washington, D.C. 20037

American Association for Health, Physical Education and Recreation
1201 16th Street, N.W., Washington, D.C. 20036

American Association of Blood Banks
1828 L Street, N.W., Suite 608, Washington, D.C. 20036

American Association of Colleges of Pharmacy
8121 Georgia Avenue, Suite 800, Silver Spring, Md. 20910

American Association of Dental Schools
211 East Chicago Avenue, Chicago, Illinois 60611

American Association of Medical Assistants
One East Wacker Drive, Chicago, Illinois 60601

American Association of Ophthalmology
1100 17th St., N.W., Room 304, Washington, D.C. 20036

American Association for Respiratory Therapy
7411 Hines Place, Suite 101, Dallas, Texas 75235

American Cancer Society
219 East 42nd Street, New York, New York 10017

American College Health Association
2807 Central Street, Evanston, Illinois 60201

American College of Hospital Administrators
840 North Lake Shore Drive, Chicago, Illinois 60611

American College of Nurse-Midwives
50 East 92nd Street, New York, N.Y. 10028

American College of Obstetricians and Gynecologists
One East Wacker Drive, Chicago, Illinois 60601

American Corrective Therapy Association
Public Relations Officer
1781 Begen Avenue, Mountain View, California 94040

American Dental Assistants Association
211 East Chicago Avenue, Chicago, Illinois 60611

American Dental Association
211 East Chicago Avenue, Chicago, Illinois 60611

American Dental Hygienists' Association
211 East Chicago Avenue, Chicago, Illinois 60611

American Diabetes Association
18 East 48th Street, New York, N.Y. 10017

American Dietetic Association
620 North Michigan Avenue, Chicago, Illinois 60611

American Foundation for the Blind
15 West 16th Street, New York, N.Y. 10011

American Heart Association
44 East 23rd Street, New York, N.Y. 10010

American Home Economics Association
2010 Massachusetts Avenue, N.W., Washington, D.C. 20036

American Hospital Association
840 North Lake Shore Drive, Chicago, Illinois 60611

American Industrial Hygiene Association
210 Haddon Avenue, Westmont, New Jersey 08108

American Library Association
50 East Huron St., Chicago, Illinois 60611

American Lung Association
1740 Broadway, New York, N.Y. 10019

American Medical Association
535 North Dearborn St., Chicago, Illinois 60610

American Medical Record Association
875 North Michigan Ave., Suite 1850, Chicago, Ill. 60611

American Medical Technologists
710 Higgins Road, Park Ridge, Illinois 60068

American Medical Women's Association
1740 Broadway, New York, N.Y. 10019

American Medical Writers' Association
2900 Grove Road, Thorofare, New Jersey 08086

American National Red Cross
17th and E Streets, N.W., Washington, D.C. 20006

American Nurses' Association
Careers Program
2420 Pershing Road, Kansas City, Missouri 64108

American Occupational Therapy Association
6000 Executive Blvd., Suite 200, Rockville, Md. 20852

American Optometric Association
7000 Chippewa Street, St. Louis, Missouri 63119

American Orthoptic Council
55 University Avenue, Toronto, Ontario, Canada

American Osteopathic Association
212 East Ohio Street, Chicago, Illinios 60611

American Pharmaceutical Association
2215 Constitution Avenue, N.W., Washington, D.C. 20037

American Physical Therapy Association
1156 15th Street, N.W., Washington, D.C. 20005

American Podiatry Association
20 Chevy Chase Circle, N.W., Washington, D.C. 20015

American Psychiatric Association
(Joint Information Service)
1700 18th Street, N.W., Washington, D.C. 20009

American Psychological Association
1200 17th Street, N.W., Washington, D.C. 20036

American Public Health Association
1015 18th Street, N.W., Washington, D.C. 20036

American Rehabilitation Counseling Association
1605 New Hampshire Avenue, Washington, D.C. 20036

American School Health Association
107 South Depeyster Street, Kent, Ohio 44240

American Social Health Association
1740 Broadway, New York, New York 10019

American Society for Medical Technology
5555 West Loop, Houston, Texas 77401

American Society of Clinical Pathologists
2100 West Harrison Street, Chicago, Illinois 60612

American Society of Electroencephalographic Technology
University of Iowa, Division of EEG & Neuro-physiology
500 Newton Road, Iowa City, Iowa 52240

American Society of Radiologic Technologists
500 North Michigan Ave., Suite 8, Chicago, Illinois 60611

American Speech and Hearing Association
9030 Old Georgetown Road, Washington, D.C. 20014

American Veterinary Medical Association
600 South Michigan Avenue, Chicago, Illinois 60605

Arthritis Foundation
1212 Avenue of the America, New York, N.Y. 10036

Association of American Medical Colleges
One Dupont Circle, N.W., Washington, D.C. 20036

Association of Medical Illustrators
Medical College of Georgia, Augusta, Georgia 30902

Association of Medical Rehabilitation Directors and Coordinators
3830 Linklea Drive, Houston, Texas 77025

Association of Schools of Allied Health Professions
One Dupont Circle, Suite 300, Washington, D.C. 20036

Association of Schools of Public Health
1825 K Street, N.W., Suite 707, Washington, D.C. 20006

Association of University Programs in Hospital Administration
One Dupont Circle, Suite 420, Washington, D.C. 20036

Biological Photographic Association
P.O. Box 12866, Philadelphia, Pennsylvania 19108

Blue Cross Association
840 North Lake Shore Drive, Chicago, Illinois 60611

Council for the Advancement of Science Writing
201 Christie Street, Leonia, New Jersey 07605

Epilepsy Foundation of America
1828 L Street, N.W., Suite 406, Washington, D.C. 20036

Goodwill Industries of America
9200 Wisconsin Avenue, Washington, D.C. 20014

Hospital Financial Management Association
840 North Lake Shore Drive, Chicago, Illinois 60611

International Association of Milk, Food and Environmental Sanitarians
P.O. Box 437, Shelbyville, Indiana 46176

Maternity Center Association
48 East 92nd Street, New York, New York 10028

Medical Library Association
919 North Michigan Avenue, Suite 2023, Chicago, Illinois 60611

Muscular Dystrophy Associations of America
810 Seventh Avenue, New York, New York 10019

National Association for Mental Health
1800 North Kent St., Rosslyn Sta., Arlington, Va. 22209

National Association for Music Therapy
P.O. Box 610, Lawrence, Kansas 66044

National Association for Practical Nurse Education and Service
1465 Broadway, New York, New York 10036

National Association of Dental Laboratories
3801 Mount Vernon Avenue, Alexandria, Virginia 22305

National Association of Hearing & Speech Agencies
814 Thayer Avenue, Silver Spring, Maryland 20910

National Association of Social Workers
600 Southern Building, 15th & H Streets, N.W., Washington, D.C. 20005

National Council for Homemaker-Home Health Aide Services
67 Irving Place, New York, New York 10003

National Council on Alcoholism
Two Park Avenue, New York, New York 10016

National Council on the Aging
1828 L Street, N.W., Washington, D.C. 20036

National Cystic Fibrosis Research Foundation
3379 Peachtree Road, N.E., Suite 950, Atlanta,
Georgia 30326

National Easter Seal Society for Crippled Children
and Adults
2023 West Ogden Avenue, Chicago, Illinois 60612

National Environmental Health Association
Office of the Executive Director
1600 Pennsylvania, Denver, Colorado 80203

National Executive Housekeepers Association
Business & Professional Bldg., Gallipolis, Ohio 45631

National Federation of Licensed Practical Nurses
250 West 57th Street, Suite 323-25, New York,
New York 10019

National Foundation
1275 Mamaroneck Avenue, P.O. Box 2000, White Plains,
New York 10602

National Hemophilia Foundation
25 West 39th Street, New York, New York 10018

National League for Nursing
Ten Columbus Circle, New York, New York 10019

National MEDIHC Program
Bureau of Health Resources Development
Federal Building, Room 514
7550 Wisconsin Ave., Bethesda, Maryland 20014

National Medical Association
2109 E Street, N.W., Washington, D.C. 20037

National Multiple Sclerosis Society
257 Park Avenue South, New York, New York 10010

National Rehabilitation Association
1522 K Street, N.W., Washington, D.C. 20005

National Safety Council
425 North Michigan Avenue, Chicago, Illinois 60611

National Society for the Prevention of Blindness
79 Madison Avenue, New York, New York 10016

National Urban League
55 East 52nd Street, New York, New York 10022

Registry of Medical Rehabilitation Therapists and Specialists
5308 Locust Street, North Little Rock, Arkansas 72116

Society for Public Health Education
655 Sutter Street, San Francisco, California 94102

Society of Nuclear Medical Technologists
1201 Waukegan Road, Glenview, Illinois 60025

Society of Nuclear Medicine
211 East 43rd Street, New York, New York 10017

Student American Medical Association
1400 Hicks Road, Rolling Meadows, Illinois 60008

Student National Medical Association
2109 E Street, N.W., Washington, D.C. 20037

United Cerebral Palsy Associations
66 East 34th Street, New York, New York 10016

Alcohol, Drug Abuse, Mental Health Administration
6500 Fishers Lane, Rockville, Maryland 20852

Bureau of Health Resources Development
Information Office
Bethesda, Maryland 20014

U.S. Office of Education
Division of Vocational & Technical Education
Dept. of Health, Education & Welfare, Washington, D.C. 20202

U.S. Training & Employment Services
Division of Occupational Analysis & Career Information
1741 Rhode Island, Avenue, N.W., Washington, D.C. 20210

D. MEDIA RESOURCES

Audio-visual Media from Commercial Sources
(compiled by Audiovisual Dept., Simmons College, Boston)

1) Audio (phonograph records, tapes, cassettes, etc.)

a) Library of Congress Catalogs - Music: Books on Music and Sound Recordings (Formerly L of C Catalog - Music and Phonorecords). "... contains entries for sound recordings of all kinds, whether these are musical, educational, literary, or political." Published in June and December. Lists manufacturer/distributor, date, and a brief description of contents.
Ref. Z 881/A14 U53

b) Schwann Record and Tape Guide. Equivalent to Books in Print for these media, Schwann comes in two parts:

Schwann - 1 Monthly. Special new listing section has latest releases: records, 8-track cartridge and cassette tapes. 45,000 total listings on 773 labels in classical, opera, ballet, recent popular, rock, jazz, musical shows, country, quadraphonic, etc.

Schwann - 2 Semi-annually. Expands coverage of Schwann-1 in specialized categories: pop more than two years old, classic jazz, older and re-released mono and reprocessed stero classical recordings, classical on lesser-known labels, international pop & folk on domestic labels, spoken, educational, religious, etc.

c) NICEM (National Information Center for Educational Media) Index to Educational Records. Classed subject arrangement, followed by alphabetical listing of titles, which includes description of contents, names of producers/distributor, etc. Published every other year.
Ref LB 1044.3/29 N33

d) NICEM Index to Education Audio Tapes.
Ref. LB 1044.4/29 N3

e) Educators Guide to Free Tapes, Scripts, and Transparencies. Classed subject arrangement; indexes for titles, subjects, and sources. Annual.

2) Visual (films, slides, filmstrips, etc.)

a) Feature Films on 8mm and 16mm. Compiled and edited by James Limbacher, 1974. Subtitled: "A Directory of Feature Films Available for Rental, Sale and Lease in the United State." Updated by monthly in Sightlines (L.S./ Periodical)
Ref. PN 1998/L-8

b) NICEM Index to 16mm Educational Films. (3 volumes)
Ref. LB 1044/Z9 N 35

c) Educators Guide to Free Films.
Ref. LB 1044/E8

d) NICEM Index to 35mm Filmstrips (2 volumes)
Ref LB 1044/29 N36

e) Educators Guide to Free Filmstrips.
Ref LB 1043.8/E4

f) NICEM Index to Educational Overhead Transparencies. (2 volumes)
Ref LB 1043/29 N3 sup

g) NICEM Index to Educational Video Tapes.
Ref LB 1044.7/Z9 N3

h) NICEM Index to 8mm Motion Cartridges.
Ref LB 1044/Z9 N34

3) Multimedia

a) NICEM Update of Nonbook Media. Monthly update & supplement all the NICEM Indexes: subject guide - multimedia, and alphabetical title guide - by specific medium. Published in alternating years with the Indexes.
Ref LB 1043/Z9 N34

b) Audiovisual Marketplace. Annual multimedia guide listing producers, distributors, manufactuers, associations, reference sources, reviewing media, et al.
Ref LB 1043/A817

c) NICEM Index to Producers and Distributors.
Ref LB 1043/Z9 N3

d) International Index to Multi-Media Information. (formerly Film Review Index). Vol. 1-, 1970- Quarterly. The alphabetical listing by title includes full citations to reviews and short extracts from specific reviews. Also included are a Subject Index and Distributor List. A major index to reviews in the audio-visual media.
Index Shelf.

f) Media Review Digest. (formerly Multi-Media Reviews Index). "...annual index to and digest of reviews, evaluations and descriptions of all forms of non-book media....supplemented by regular installments (for educational materials) appearing in Audiovisual Instruction..." Comes in two parts:

Part 1: Films, Filmstrips, Miscellaneous Media
Part 2: Records and Tapes

Offers lists of awards and prizes, mediagraphies (i.e. filmographies and discographies). Arranged alphabetically by title with very detailed cross references.

II. SOME TEACHING - LEARNING METHODS FOR INTEGRATING INFORMATION IN THE CLASSROOM

A. Exercises

1) Simulated Public Hearings: Students would choose to become part of a group (thirteen - fifteen students) project to present a public hearing on one of the Project Problems (see below) comparable to a Congressional hearing. Group members would be responsible, for example, for defining the problems clearly, raising important questions, and others would offer

their point of view as to solutions of various health services, health business, professional, consumer (including ethnic, regional, age, sex, environmental, labor, religious, etc.) groups; and may become (or invite) "expert witnesses" to present special information. International comparative data might also be used. Witnesses would be questioned by the "Congressional Panel", and also by the "audience", (classmembers and faculty). The group as a whole would provide a suggested reading list to the class at least a week prior to presentation.

2) An analytic and comparative research paper on an operationally-defined issue or problem (avoiding simple "pro-con" discussions and placing the issue in a larger, system context)

3) "Translations" of above into a presentation or article format geared to a specific consumer group.

4) Simulated joint (group) planning-implementing-evaluation process with built-in self-critique, consisting, for example, of

   a) A description of a specific health scarcity area (selected from Office of Monitoring and Analysis Bureau of Community Health Service Health Service Scarcity Areas (HEW, Oct., 1973): population data from the U.S. Statistical Abstract 1974, and health-age profiles in Facts of Life and Death (National Center for Health Statistics, 1970, PHS Pub. No. 600) Integrated county data is available in the Area Resource File, Bur. of Health Resources Div., HRA, HEW, Rockville, Md.

   b) A plan for a health delivery system for that area.

   c) Possible impediments to (b)

   d) How do deal with these impediments

   e) How to implement the plan

   f) Barriers to implementation

g) How to overcome these barriers

h) A critique of the entire approach (b) - (g)

5) Building Bridges - developing processes and patterns (in language, personnel, institutions, places) that are usable in common between teachers-students, disciplines, schools, service facilities, providers-consumers, communities-institutions.

B. Project Problems
(to be carefully refined by students)

1) What should be the relationship, if any, of any one of the following to a system of health services: programs/policy concerning

a) the physical environments

b) food and nutrition

c) income maintenance (social security, pensions, public assistance)

d) general education

e) health occupations' training?

2) What should be included in effective "preventive" health services?

3) What should be the organization of home care services (e.g., ranges of benefits, location, for whom, how paid, relations with other programs, etc.)

4) What should "health education" include? When? Where?

5) Should NHI cover comprehensive benefits or be restricted (e.g., to catastrophic benefits or to special groups as elders, poor, disabled)?

6) How should the environment be changed to improve health?

7) How should health services be changed to most contribute to health?

Consumerism in Health Care Delivery: Its History in Time and Space by Leslie Falk, M.D.

INTRODUCTORY

Cincinnati is a particularly congenial place to be talking about the consumer in health care delivery - especially about the consumer - oriented health center. In 1915, Wilbur C. Phillips and his wife, Elsie Cole Phillips, involved neighborhood residents in one of the very first health centers in the United States here in Cincinnati. They started "the block plan", for local consumers to do health surveys and to relate to "their" health center. One person from each block was responsible for contacting and bringing mothers to the health center, which concentrated on services for mothers and children. This was an involvement of neighborhood residents which is still one of the basic patterns of consumer participation.[1]

Each block had a representative on the board of management of the health center, and helped decide its policies, another basic pattern. So, Cincinnati scored a major "consumer participation" United States first. However, these particular efforts were later destroyed, because the Phillips' were socialists in thought and political opinion here succumbed to the anti-Bolshevik hysteria of the early 1920s, and the Phillips' had to leave Cincinnati.

By 1926, the Shoemaker Health and Welfare Clinic was organized in the West End of Cincinnati, described as the "Negro Quarter," in the former mansion of Mrs. Michael M. Shoemaker. A year later, Mr. James H. Robinson, executive secretary of the Negro Civic Welfare Association described its "remarkable year of service ... with 1,823 patients, making 5,377 visits to the Clinic." Eleven "colored" and seven white physicians rotated for four month periods. Other personnel included two "colored" dentists, over two fulltime nurse-equivalents, a dental assistant and a registrar. Ten cents per visit plus ten cents for medicines was charged.[2]

Today, in Cincinnati, you have many health centers - and their near relatives for similar purposes. These include the Lincoln Heights Health Center, the Mt. Auburn Health Center, the Pilot City Health Service and others of the Cincinnati Health Department, of Ambulatory Patient Care, Inc. and at the University of Cincinnati

Medical Center, Ambulatory Patient Services. All of these have consumer involvement, in varying degrees.

It is in these centers that real life health administration problems are being worked on by the enrollees, many here tonight, of the Work-Study Institute for Health Professions Faculty of your University's Program in Community Health Organization.

THE UNDERGROUND RAILROAD AND FREEDOM

Cincinnati is also of great interest as one of the best-known stations on the Underground Railroad. The Underground Railroad helped slaves escape in a period when this form of civil disobedience was an essential pathway to freedom.[3] We can call this a community health activity - certainly a community mental health activity - and one of great importance. Levi Coffin, a Quaker, was stationmaster of the Cincinnati underground railroad, and probably the Underground Railroad's national president.[4] And, it was her Cincinnati period of residence and experiences which inspired Harriet Beecher Stowe to write Uncle Tom's Cabin, a novel which sold 300,000 copies in its first year of publication. It led to a widely performed play, to other forms of expression, and helped influence whole generations of public opinion against slavery and for fugitive slaves and their allies - white or free-black.[5]

While he was a medical student in Cincinnati, Dr. Norton S. Townshend was a conductor on the Underground Railroad. Professor Townshend was one of the organizers of Ohio State University in Columbus. Incidentally, another early Ohio stationmaster on the Underground Railroad was physician Jared P. Kirtland of Poland, Ohio in Mahoning County, further north, where he lived between 1823 and 1837.[6]

CONSUMERISM IN HEALTH CARE DELIVERY AROUND THE WORLD THROUGH TIME

Now to a brief panorama of the consumer in health care delivery around the world and through history. The words describing the forms of consumer involvement in health care delivery constitute a breath taking list, including health insurance, public medical services, friendly societies, fraternal associations, mutual benefit societies, the health reform movement of the nineteenth century, the women's health movements of the nineteenth and twentieth centuries, trade union health centers, neighborhood health centers, comprehensive health centers, family health centers, free clinics - all these, and more, describe the basic fact of the public and the health care providers working together, consciously or subconsciously.[7] In the U.S. today many of the most dynamic leaders in the consumer health movement are women, black, brown, red, yellow and poor - white

people. Some of us white males try to be helpful.

Consumer control is perhaps the most controversial phrase in this history. Allied to that in concept is the phrase a national health rights system, applied in the U.S.A. today to one possible type of national health program, and as an alternate to national health insurance.

In concept and in behavior elsewhere in the world, perhaps the Chinese ideas represent the greatest challenge to our traditional assumptions. The "barefoot doctor" and the community's choosing which students enter medical school are expressions of a strikingly different stance on the basic relationships of health services.

We know more about the history of health insurance and state services in Europe than in Africa or Asia. Medical care prepayment was widespread in medieval and renaissance Europe. The Knappschaftkassen (fraternal society chest), Krankenkassen (sick chests), caisses ("funds"), mutualities and many other related words are used to describe the sickness, accident and medical care insurance funds collected by consumers to help meet the costs of medical and hospital care, as well as to replace wage loss due to sickness, accident or disability.

The medieval guilds built hospitals, employed physicians and set up "sick chests". Because the guild was mainly concerned with the protection of the craft and the defense of their economic interests, social solidarity was secondary. That required the charity services offered by the church. But, members of the same craft did unite and attach great importance to mutual aid. These were important plans, even though local and specialized, but they were not a solution for the entire population. By the nineteenth century, the guilds ceased to exist, as such, and new forms of organizations replaced them.

TRADE ASSOCIATIONS

The formation of trade associations of workers grew in the first phase of capitalism. Many people were attracted to the cities, but they had to work under inhumane conditions, bad for men, women and for young children. Huge numbers became ill, disabled, malnourished and/or alcoholic. Disability and sickness became vast problems, while social protections were minimal.

As these employees demanded some health protection, these needs were stated to public authorities, and efforts were made to establish protection against sickness risks under the British Poor Law. Mutual aid societies developed in the form of voluntary health insurance.

FRIENDLY, FRATERNAL AND BENEVOLENT SOCIETIES-BRITAIN

The friendly societies of England can be traced from the late seventeenth century. The Friendly Society of Bethnal Green was founded in 1687.[8] These societies increased rapidly in numbers during the nineteenth century.

They were formed by working people who recognized the importance of fighting the poverty caused by sickness and premature death, and who knew they could get little or no help from the state. At first, there were many small local societies, but then a few great national orders developed e.g., the Manchester Unity of Oddfellows and the Ancient Order of Foresters. One society was all-female. Some were religious e.g., the Baptist Sunday School Sick Society. Some were established on temperance principles. The Rechabites were a third large group.

The British friendly societies achieved a membership of 925,000 by 1815, and grew to 5,466,000 by 1899.

Only some 296,000 persons were members of perhaps seventy-five specialized medical friendly societies. On the other hand, the general friendly societies almost all had their own "lodge doctor" or "contract practice" arrangements. They usually provided dispensed drugs as benefits as well.

Deposit societies which combined the objectives of sickness benefit societies with the features of a savings bank, and "dividing societies" are other examples of these British groups. Friendly society asylums and convalescent homes were sometimes run by the friendly societies in Great Britain.

THE U.S.A.

Schwartz states:

> "The first prepaid medical plans in America were organized by fraternal societies and mutual benefit associations, which began to appear in the United States as early as 1787 with the formation of the Free African Society in Philadelphia."[9]

To those conscious of African culture and its solidarity-security systems, mutual protection of the entire family is basic. This "first" for the black community seems understandable, especially because it was based on the black church, the strongest form of black community organization.

Between 1793 and 1867, about 38,000 benevolent societies were formed in the United States. Many were unsound and by 1867, the number had fallen to 24,000. Before developing this subject further, however, let us describe a consumer health care development, starting in the 1830s which has much of the same excitement, unconventionality and passion as does our current health care movement. However, it showed little interest in prepaying for the medical care of the regular medical profession because it was in revolt against them.

THE POPULAR HEALTH REFORM MOVEMENT IN THE UNITED STATES 1830 - 1850 AND SOME CONSUMER-LED HEALTH EFFORTS

A remarkable development led by the consumer in health care was interwined with professional and power-structure aspects and included revolt against the official medical profession. It led to health reforms in relation to working class developments, feminism and the abolition of slavery. Health and sex education, natural childbirth, temperance, birth control, nutrition improvement (e.g., Dr. Sylvester Graham's unrefined wheat advocacy), "natural" habits and medical regimes (such as water as a treatment method), the development of sanitoria and other trends were involved too. The public generally rejected the regular medical profession in this period, and tried self-reliance or new practitioners instead.

Important accounts of the period are given by Henry Shyrock[10] and by John Blake, whose "Mary Gove Nichols, Prophetess of health"[11] discusses the feminist aspect of the general reform period. A recent interpretation by Barbara Ehrenreich and Deire English, states:[12]

> "Women took self-education on sex, birth control, menstruation and other matters into their own hands. Lectures and self-education were popular."

Healers without formal "miseducation" arose. One outstanding example is the black abolitionist, David Ruggles, essentially a self-trained hydrotherapist. He established one of the first U.S. sanatoria in Northampton, Massachusetts.[13] "The water cure" was a widespread development, all over the nation.

The consumer-led and feminist aspects of this period are usually dismissed as the high tide of quackery and medical cultism, but another view (of Ehrenreich and English) is that:

"The movement was a radical assault on medical elitism and an affirmation of the traditional people's medicine. Every man his own doctor,... and ... they meant every woman too."

When the "regulars" organized the first national medical organization, the American Medical Association (AMA), numerous reasons were given why women should not practice medicine. Attitudes towards women are illustrated by the presidential address in 1871, when Dr. Alfred Still said:

"Certain women seek to rival men in money, sports ... and the strong minded ape them in all things, even in dress. In doing so they may command a sort of admiration such as monstrous productions inspire, especially when they aim towards a higher type than their own."

Consumer-led health reforms declined later in the nineteenth century. The grassroots energy ebbed and the movement by then had degenerated into a set of competing sects. Consumers took to other forms of effort as the century wore on.

I want to shift back to the stream of the fraternal society and to the voluntary health associations of the lodge doctor. Father Upchurch of Meadville, Pennsylvania in 1868 founded the ancient order of United Workman.[14] It was a model imitated by many groups based on the work relationship of workfellows whether it was by craft or other association. In addition, the nationality pattern was a major factor; people brought over from the old country the security systems that they had had there. For example, the French Mutual Benefit Society started in San Francisco[15] in 1851, during the gold rush period when there was no hospital or medical care. It was a mutual benefit society that built a hospital and ran a prepaid medical care program: a hospital-based HMO, the godfather in some ways of the Kaiser Plan. This type of system developed in the big cities and in the rural mining, lumber and railroad industries. In other words, they were mostly associated with remote industries that weren't in settled communities; not so much in the rural farmer setting. The Fraternal Order of Eagles as another example, had a membership which soared to 500,000 by the turn of the century.

Essentially, these systems were all under-financed. They were based on low income people who didn't have all that much cash. The

doctors needed these systems in order to make a living. They needed them to get a start in practice and needed them as an assured base, but they felt over-worked and underpaid. Many of the current attitudes in the debates of medical society stem directly from this identification of prepayment with exploitation. It has also led to the huge emphasis on doctor dominated prepayment and an orientation towards commercial insurance without a fixed physician income. In other words, the indemnity system of paying towards commercial services but not paying for all of them.

It was not until the twentieth century that a trade union developed a health center. The International Ladies Garment Workers Union in New York City developed a health center after the terrible Triangle Shirt Waist fire which killed large numbers of garment workers.[16] In the same period a Public Health Service report had pointed out the devastatingly high rate of tuberculosis in the garment industry. These services were developed with an emphasis on prevention because of this kind of background and later developed into the union health center stream which was particularly strong after World War II. The services were of a general ambulatory nature particularly diagnostic health examinations, non-hospitalized care. This became primarily an urban development of trade unions.

The coal miner developments became the first independently administered health and welfare fund under collective bargaining. During World War II, the growth of insurance benefits under collective bargaining grew tremendously as an alternate to wage increases. There was a wage price freeze and at the same time, both the government and employers were interested in having a stable work force. As a result, collective bargaining for health and welfare funds, death benefits, pensions, sickness benefits and hospitalization, medical care benefits grew tremendously. Most of this development is as you know it today. Collective bargaining insurance premiums generally go to Blue Cross, Blue Shield and commercial insurance. But the mine workers program at that time covering two million people, with families all over the country, developed an independently administered program and developed community health centers in order to improve prevention, primary care, and rehabilitation services. The bargaining effort spoke very early in the forties about unnecessary hospital days or the more elegant phrase "ineffective use" of the hospital bed, meaning that half of the premium was going to pay room and board for cases who could receive the care in the office or the home. Therefore, the mine workers program became "Peck's bad boy" of the whole health movement of the forties because it was "belling some cats"

which were later seen by organized medicine and the government as important considerations. The question of bed utilization committees for quality of care, peer review, and quality assurance, were a series of the phrases used today which entered early into this self-administered program.

Well, meanwhile in rural areas, there had developed consumer sponsored health plans parented after the Rochdale kind of cooperative of Rochdale, England. The Rochdale Coop Movement, a consumer movement, was the origin of the Group Health Association of Washington, D.C. a particularly important one because of organized medicine's opposition to it. This opposition resulted in a Supreme Court decision establishing the legality of consumer-sponsored medical care insurance plans. The District of Columbia Medical Society had not only forbade its members from participating but it declared consultation unethical for a member of the Group Health Cooperative. The Supreme Court founded both the American Medical Association and the D.C. Medical Society in violation of the Sherman Anti-Trust Act. This legal victory was a turning point in consumer sponsored plans.

The Group Health Cooperative of Puget Sound became a highly successful cooperative. It built its own hospital and today is one of the strong large membership organizations of the Group Health Association of America. That terminology "group health association" was the dominant terminology of the forties and a good part of the sixties. It is one definition of a health maintenance organization and, I think, essentially the government definition of an HMO is pretty near what the group health plan is.

The community sponsored group health plan or prepaid group practice plan developed par-excellence in New York City. The Health Insurance Plan of greater New York and the flamboyant Mayor LaGuardia brought into the plan large numbers of city employees as a stable base for group practices. The plan attempted to avoid building its own hospitals by using community hospitals and by using Blue Cross. That pattern did not seem to thrive, however, as much as did the hospital-based, prepaid group practice.[17]

Well, then we come to the explosion of the sixties, the Black revolution, the birth of the poverty program and the neighborhood health center: the comprehensive care center which so many know today. I say predominantly the Black revolution because that was the consciousness that had most of the forces that were so powerful; however, Appalachia's poor whites, Chicanos, the Puerto Ricans, and others related to this explosion and voiced their dissatisfactions as the poorest of the poor. Previously there had been a great deal of selection toward the employed individual, the blue collar worker

and in some plans, white collar workers. But here, the resentments against long waits in the hospital on hard benches, the lack of privacy led to the demand for personalized care. They led, in many ways, to a unification of the preventive medicine, the public health stream and the family practice stream.

The demand for the personal physician was basic and there was no longer a starry-eyed attitude towards the aggregation of specialists which had been the case with the term "medical group practice" stemming from the Mayo Clinic. These forces essentially rejected the specialization drive within the medical profession and felt that a personal physician and continuity of physician care mattered. The public has always, in one way or another, either passively or actively, demanded continuity, a personal physician, and recognition that psychological aspects of health services be a part of their health care. So the Equal Opportunity Act was amended rather promptly in the mid sixties to develop the neighborhood health centers under the comprehensive health center program to give this kind of service.

In that same decade, the comprehensive health planning legislation brought public community leaders into an authoritative position in the geographical area of planning. Much of this involved the power structure with industry leaders saying: "We don't want fund drive after fund drive." "We don't want each institution to be coming to us for its own hospital expansion." To a certain extent, this development included real community leaders who directly represented lower income communities.

Then more recently we find the formation of the free clinics,[18] store front clinics which tended to include youth types and hippie types. Many were skeptical of the lasting power that these represented. But maybe the Chinese and the free clinics reflect the trend for the future. In many ways these have found a way to make health maintenance and health care related to real problems: sex related problems, drug addiction and psychological problems, etc. Perhaps we will continue to see this unofficial system.

Well, to end. Where are we at the social policy level. We have been year after year at the question of what is our national health system going to be? For a period of time, Medicare took the steam out of the national health insurance development but now we have nearly everybody being in favor of the national health insurance. Even President Nixon used that phrase; everybody used the phrase. Then we found ourselves in a depression, so there was a coming up for air and a postponement. No national system developed. Obviously, there are pre-existing vested interests in the commercial

insurances, the Blues and the medical society. There is generally a desire for government assumption of some of the risks of the voluntary system.

By and large the consumer movement has looked to social security and government administered services through, for example, the Kennedy Bill. This movement would primarily have had social insurance administered in a number of health regions, not by the Blues, not by commercial insurance, but by a new health insurance system or by fiscal intermediary relationships. The most radical components of the consumer movement are now demanding a Health Rights program which would enact nationally the concepts of consumer control of local retention of monies, and include the unofficial components of the health system such as the women's health movement and the free clinic.

I think we have a breather for this year. We may have a breather yet for a while longer, but I can not see that we have a very long breather and it would appear to me that on our agenda of urgent social policy through debate, sharing of views, clarifying views and getting new ideas - is the whole question of how we can maintain the values of people making decisions for themselves, maintaining local monies (as opposed to nationalized bureaucracies), and yet at the same time, including all of the dimensions that have come up through the consumer movement. The dilemma is apparent with no clear cut answers.

I would like to close then, with several quotes from my great medical history teacher, Henry Sigerist[19], which I think will express basically where we have been and where we are:

"Health cannot be forced upon the people ... They must want it and be prepared to do their share."

"The peoples' health is the concern of the people themselves. It cannot be dictated from above, cannot be dispensed by means of charity. The people must work for it, must accept the responsibility for health and physicians are merely experts advising the people in their struggle against disease."

"A society must be ready to fight disease. The people must want health. They cannot be too ambitious in health matters."

"Disease and health must be studied in space and time. All societies have a social organization to fight disease."

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Preparing Health Administrators for Future Roles

by James G. Haughton, M.D., M.P.H.

Since I understand that the participants here are either program directors or people who have training responsibilities in schools of health, and faculty of health services management programs, I want to talk to you about what we need in the field, and what you should be teaching the young people who come through your programs. I have occasion to hire a lot of young people. Our system is large, we have some 9,000 employees in three hospitals, four neighborhood health centers, a school of nursing, and we are, therefore, frequently looking for young people of talent. What I find is that applicants have had their heads filled with health care philosophy, a lot of data, and a lot of notions about community participation, but they have not been taught how to manage anything. What I want to talk to you about is some of the concepts that your graduates must bring into the world of work, and some of the skills that they must bring with them. Granted, you cannot teach them everything they need to know, but what you are giving them is a base on which they can build. They must bring something to the organization, because we are not running a school, and we cannot start with someone to whom we have to teach everything that he has to do from the first day. We can teach him what he has to learn for the future.

We have tried to develop a system in which there are career ladders, in which people can grow. At Cook County Hospital, there are the usual four major departments: Medicine, Surgery, Obstetrics and Gynecology, and Pediatrics. One of the things I had to do when I went to Chicago was to run Cook County Hospital for a year. That is not what I went there for. I went there to organize and establish the governing commission, the hospital commission, that was supposed to run those institutions. I had a good director at the large chronic disease facility we operate, but there was no director at Cook County, and apparently the appropriate people in Chicago were too smart to take the job. I offered it to a couple of good people, one of whom accepted the job two years later after most of the problems had been solved. But, for the first year, I had to run the hospital myself. There was no management at any level in that hospital. We have reorganized it so that today there

is an assistant administrator in each of those major departments. Every department of Cook County Hospital is larger than eighty percent of the hospitals in this country. As you may be aware, most of the hospitals in this country are under 200 beds. The Department of Medicine at Cook County has 405 beds; the Department of Surgery has about 520 beds; the Department of Pediatrics has 275 beds; and the Department of Obstetrics and Gynecology has about 200 beds. So, each of those departments is a sizeable hospital, and there was no management in any of them. Today, there is an assistant administrator for each of them, and three of those people were people who were unit managers five years ago when I went to Chicago. Unit managers at that time were a group of glorified clerks the nursing services had created to do the paper work for them. They were sort of self-defense for nursing; they did not manage anything. They just did a lot of paper work, and none of the paper work they did really had much to do with the administrative functions of the hospital. They had more to do with the administrative functions of the Nursing Department. We took those people, there were about fifty-five of them, none of whom were college graduates, all of whom were high school graduates, and we contracted with a local university to design a one-year hospital management program for them, for which they got a certificate and college credits, and we made them unit administrators. We upgraded their salaries, and gave them responsibility and authority to run their units. Each unit is composed of approximately 100 to 120 beds, depending on the kind of activity. Our Cardiac Intensive Care Unit, for example, has only thirty beds, and that is considered a unit, but the level of activity in a thirty-bed Intensive Care Unit is considerable. It may be more than an ordinary 100-bed unit in Surgery unless you are in one of the very critical areas. So, we tried to design the units to be relative, not only to size, but to intensity of activity, and we gave the managers full authority to carry out the hospital administrative functions in those units. Three of those people with whom we started as unit administrators have gone through a couple of levels of promotions, and they are now assistant administrators in those departments, meaning that they have full authority for all administrative functions, in a 400-bed unit, a 200-bed unit, a 275-bed unit, and a 500-bed unit. Not a single one of them has a college degree or a masters degree in hospital administration. They are all earning in excess of $17,000 a year, because we created the training for them within our organization with a career ladder. These young people will be able to leave us at any time and if someone else looks at their experience rather than at their credentials, they have a bright

future in the health industry.

It seems to me then that what you need to do is to teach your students skills that they are going to need when they have to go into an organization. Let us talk about some of those skills. I gather that the major concern of this series of seminars is the inner-city health services. To a great extent that will mean neighborhood health centers and health programs at that level. That will immediately confront these young people with the notion of community participation. Now, you may think that I am opposed to community participation. I am not. I think it is an important asset that has not been exploited. Many people in the health industry are afraid of community participation, and some with good reason. If you look back ten years to the war-against-poverty period, you will find that a revolution started at that time which people do not realize has taken place. I am absolutely convinced that the great consumer movement of the '70s was born of OEO's community participation in the '60s. A few years after the war against poverty started, those who were not poor began to realize that if the poor folks were going to be participating, they had better start participating, too. I think much of the consumer effort and consumer organization of the late '60s and '70s probably had its origins in much of the activism of neighborhood groups that started when OEO said "maximum feasible participation of the poor". The problem with that was that the only word in that clause that was defined was "poor". Nobody bothered to define what feasible was, and what participation meant, or what they meant by maximum. But, they did define "poor" very carefully. As a result, many community organizations that were spawned out of the OEO programs were led to believe that they were going to be decision-making bodies. But in the health field, after OEO started its neighborhood health center programs all of the programs were sponsored through delegate agencies. I do not know what happened here in Cincinnati, but I know that in New York and Los Angeles and Pittsburgh, and a few other places I visited for OEO, they found a hospital or a university and they said to them, "We'll give you the money and you establish a neighborhood health center, but you have to have a community board." The community board was the grantee in many of the instances, with the university being the delegate agency. In that setting, the delegate agency had the ultimate responsibility for the money. These boards were formed of neighborhood people. Nobody told them the limits of their authority, and so they got themselves together thinking that they were going to run these centers, and the university people and the hospital people allowed them to think that. They were allowed to make decisions until the

decisions had something to do with spending money. Then they were slapped down. I went through many hectic meetings with community groups all over this country trying to resolve some of those problems because no one had bothered to define the responsibilities of the delegate agency as opposed to the responsibilities of these community boards. At one point in the evolution of a New York health center, the director of that center walked around all day long with a shoulder holster and pistol on in full sight. That is how tense the situation got at that center. At the board meetings of another health center in California, there were fist fights, broken chairs and all kinds of things, all because no one bothered to spell out carefully what the relationships were to be beforehand.

It will be crucial to the people who come out of your programs to understand board versus executive officer relationships. They must be taught that whatever position they consider, particularly in a neighborhood program where there is a community board, they must have a clear definition of how that board sees their responsibility and their role. Several neighborhood health centers have been destroyed because boards tried to administer those programs. There is one floundering in Chicago right now, that floundered a year and a half ago, and OEO asked us to take it over. We did for a year, got it organized for them, found a good director for them, and as soon as the thing began running smoothly that board began to interfere again. I was not about to go out there and have a fight with a neighborhood board so we just told the members that we felt that they had matured enough to run their own center; things were going very well, and we did not think they needed us any more. We turned the center back over to them. They were so grateful that we thought that they had matured that they gave us a big banquet, took back their center, and we walked away. Today, they have fired the director of that center; the board is divided into two factions; and HEW is talking about not re-funding them. Again they are asking us to go there. This time I told them, "I'll go in there on one condition. You get that community board out of the picture completely. You want us to run a center, we'll run a center, but we do not need a community board at this point in time, particularly a community board divided against itself. No way am I going to get in that cross fire."

Another thing that has happened to some of those centers is that the communities have seen them as WPA projects. Most of the OEO centers which I visited over a ten-year period for HEW, as a consultant, were severely over-staffed because

people saw them as a source of jobs. In fact, before we went into one in Chicago, a management study was done, and we told HEW, "You get that staff back down to some reasonable size and then we'll go in there because I am not going in there and fire those people. You get that thing down to the proper size and then we'll go in." They did and we went in and now it is bloated again, because the community board sees it as a source of jobs for that community rather than a health service.

It is important that your students understand those dynamics, and that they recognize that when they go into those kinds of situations they are going to have to have some very special skills in dealing with community boards and that those relationships should be carefully defined before they accept those positions, or they will have a lot of grief. People have often asked me how I survived the turbulence in Chicago, and the answer is very simple. I anticipated that turbulence, and had taken the trouble to study that situation before I agreed to take the position. Before I agreed to take the job, I sat down and had a real heart to heart with the members of that governing commission, and spelled out for them what I considered my responsibilities to be and my authority, and what I expected theirs to be. I got a commitment from them that they would not cross the line into my area, and I promised them that I would not cross the line into theirs. I would recommend policy to them, I would expect them to review my policies; I would expect them to challenge them. But once they had approved them, either my policy as presented or as amended by them, implementation of that policy was my responsibility. They were not to interfere with the implementation of those policies, and if they were dissatisfied with my implementation, then they should fire me. I wanted no contract, I just wanted a commitment from them to support the policies I proposed, and to give me a free hand to implement those policies. We took on a lot of people and organizations in Chicago to make that thing turn around. We took on the state, the courts, the doctors, the nursing association, and we won every battle because my board was solidly behind me. I never led them into a fight without first defining the dimensions; I never allowed them to get hit from their blind side. I would always let them know where they could expect the flak so that they could prepare themselves. But once we got into the fight, they had to be with me all the way or they would have to look for a new executive director.

Your young people must understand those relationships and must get those kinds of commitments from their boards. Many of them are going to be asked to take over programs fresh out of

your training program, and will not have the opportunity that I had of coming up through a system and learning step by step. Because they will be in demand, many will be asked to take over small or medium-sized programs, and they will find themselves in leadership positions almost immediately. That would not happen if they came to work in an organization as large as the one I operate, or in an organization in the New York City system or in one of the large health departments; they would have the chance to grow up in an organization. But in many of the inner-city programs, they are going to find themselves in leadership positions almost immediately. You really have to prepare them in a little different way than if they were going to a hospital at a junior level and have a chance to learn on the job and grow up in the process. Many will not have that opportunity. They will come out of school with a masters degree, minority students, many of them, and go into minority communities, and great things will be expected of them. They will find themselves at the top of an organization, small though it may be. If they are not prepared to deal with the realities of the dynamics of the relationship of an executive officer to the board, they will be at a disadvantage.

There are certain skills that are important to an administrator. There are some people who think administrators are born, not made. I do not tend to agree with that. I do not believe that I was born an administrator; I never had any interest in administration for most of my life. I know other people who had no interest who learned to be administrators. But there are certain skills that administrators need and you can have an impact on the development of these skills in your students, even though some of them have the basic innate abilities which can be built on. The skills can be classified into three groups. Your administrators need technical skills. They need to know how to do some things and you can teach them how to do some of them. We will talk about some of those skills a little later. They need human skills. By human skills I mean being able to understand the impact of administrative process on people. It is possible to introduce change into an environment so rapidly that counter-forces develop. Even changes people think they want will not be accepted if those changes are not introduced properly into the environment. I encountered some of that in Chicago, where there were a lot of things to change and I was impatient to change them. Many of them had important implications on the quality of care that patients received. Plus, I had the problem of impending loss of accreditation with County Hospital, so I had external constraints that forced me to introduce many changes over a very short

period of time. Given another set of circumstances, some of the things that I did in Cook County in nine months, I probably would have done over a period of two years, but I did not have that choice. I was confronted with an accreditation visit coming in about eight months and a lot of things had to happen in those eight months or we would have lost our accreditation. Even though I was aware of the dynamics of change, and the consequences of change, I had to bite the bullet and go ahead and change. That was part of why it was crucial for me to have the absolute unanimous support of my board because I knew I was going to have to do things that people would fight against, and appropriately so, given a different set of circumstances. But I did not have the luxury of that different set of circumstances. But your students will usually not be confronted with those kinds of external constraints, and so they have to have these human skills; they have to understand the impact of change on people within an environment. Their goals may be ever so well-intended, but if they do not recognize the perceptions of people, the insecurities of people, the ego trips of people, they will find themselves developing very strong resistance to even acceptable change. I classify that kind of sensitivity as human skills, recognizing the impact of change on people, the impact of process administrative processes on people. I think some of this can be taught.

The third set of skills that I would identify as important to an administrator is what I would call conceptual skills. By conceptual skills I mean the ability to see the big picture, the ability to understand the inter-relationships of one part of the organization to another.
In an organization as large as ours, that becomes very crucial. With three hospitals vying for their place in the sun-each with an independent director who reports to me-with a school of nursing who wants its resources, too; with neighborhood health centers all seeking excellence, somebody has to look at how these pieces fit together. The director of the hospital has to see how the pieces of the hospital fit together; the director of the nursing school has to see how the pieces of the nursing school fit together; the director of one of our neighborhood health centers has to see how the parts of that health center fit together. Each of them does not necessarily have to see how all of their pieces fit into my bigger picture. I have to see that. But even in the small environment of a neighborhood health center, it is important for the director of that center to see how the pieces of that small picture fit together. So if you think about it for a moment, you will see that those skills are needed to different degrees at different levels of

the organization. The individual who is director of nursing in a neighborhood health center or even if it is a large health center needs few conceptual skills or needs a lesser degree of competence in the conceptual skills than the individual who is running the entire health center. She/he merely has to see what is happening within her/his department. Yes, there are interfaces with the rest of the institution but she/he doesn't really bear the responsibility for the entire picture. The skills that the person at each level needs are more technical. She/he should be able to know enough about nursing to know that nursing skills are being properly carried out. If she is the director of nursing services, she or he, also, needs to have some human skills because that director must understand the human impact of changes or policies that may be implemented within the department of nursing.

So while your students must understand these differences between the different compartments of skills that they need as administrators, their opportunities to exercise these various types of skills will change as they progress through the health system, hopefully upward. But, if they are to be the directors of centers, and many of them will be as I pointed out, because of the nature of the field, they will be looked to for leadership very quickly. They will need to understand these different skill areas if they are to be successful: the technical skills, the human skills, and the conceptual skills.

Now, some of them will be faced with organizational dilemmas. Either they will be asked to take over a center that is poorly organized, and they will have to reorganize it, or it may be a brand new thing. It may be something that is just funded and they may be the first director and they may have to put the organization together. So, they should understand the anatomy of an organization because if they don't they won't be able to create one.

Twice in my administrative career I have been faced with the need to build an organization from scratch. Unfortunately, I had not been taught how to do that in any of my training in pursuit of my degree in Health Administration. Fortunately, I had recognized the need and had gone back to school at night and learned something about management. So, I really didn't learn my administrative skills in the school of public health. What I learned there was a lot of data, a lot of health philosophy, and I guess things that were good for me, they gave me a certain point of view about health but they certainly didn't teach me how to manage anything. I went back to management school for that and learned a lot of it on the job. But if

your students don't understand the anatomy of an organization, they won't be able to build one. And some of them will be required to put something together off a piece of paper. Somebody will give them a proposal that was just funded and they will be expected to translate that piece of paper into an organization. They have to understand how you build an organization.

I have my own theories about how you do that. I don't know if they jive with any books on organizational theory. I have read some of those books. In my view, you build an organization functionally. You start by defining the objectives of the organization: Why does this organization exist? What is it supposed to do? Once you have defined that, then you have to ask yourself what functions are required to get from here to there. And you build your organization around the answers to those questions. If you don't want to be in trouble, you answer some of those questions before you take the job because if you don't, you may find yourself on the job without the appropriate resources to do the job or without the appropriate commitment from your board to get it done, because they have to know what is required to get it done, too.

When I was asked to take this job at the governing commission, I went away for about two weeks to think about it and to decide what kind of organization I was going to build. As I mentioned earlier, I started defining for myself what I thought the objectives of the organization were to be, and then tried to analyze the various functions that would be required to make that organization work. I worked out on paper what I thought the parts of the organization should be. I think that is a skill that you should teach your students. You should give them a proposal that somebody has written or some kind of a program, and ask them to create an organization to implement that proposal. See what they do with it. I think the results of their work will give you an opportunity to teach them the process of how you translate a piece of paper with somebody's ideas about a program into an organization and a staff to do that.

Health Care for Outcasts by Nancy Milio, R.N., Ph.D.

I would like to start by making a distinction between a couple of concepts. That is the distinction between the concepts of "intent" and "effect"; "intent" meaning the sense of purpose or motive, and "effect" as the notion of consequence or outcome. I point out the difference between these two concepts because when we are talking about health care -- and we come out with the fact of the real mess that we have, the outcome, the consequence of decisions that have been made lo these many years -- it is easy to impute the reason as this group or that group intended it that way. In some situations that may be, but that is not necessarily the case. There is no necessary connection between consequences of what has been done and individuals' intentions. In general, people in health care have had good intentions, but bad consequences have resulted in terms of the overall decisions affecting groups of people and the health care that they have gotten.

I first learned this myself as a visiting nurse, when I started asking questions about why what we were doing was having no effect at all in improving the health of people in the ghetto. My colleagues did not hear the question as a question about the consequences of what we were doing; they heard it as a questioning of their intentions. They perceived me to say, "You're intending to do a sloppy job or you're not doing a good job; therefore there's something wrong with you". And as soon as people hear that, of course they block everything else; they think you're impugning their intentions - their good intentions.

The problem for us today is how to take the good intentions of people who get into health care because they want to do something that's helpful, and channel it organizationally so that the consequences of that energy and of what people do turn out to be as good as their intentions are. It is a problem of deciding how human resources, which really are also financial and organizational resources, should be allocated so that they can impact on the health of various groups of people in various places in such a way that their health is improved, and not have a zero effect or a negative effect.

There is an assumption that often is made by health professionals, that the poor - people in the central city - do not value health as much as more affluent people do. What you find in the few studies that try to deal with this question is that for people whose income is less than a modest survival level - their primary concerns were, indeed, food, housing, and jobs. What that is really saying is not that poor people don't value health, but that indeed they value health in its most generic sense. What possible value are health services if you do not have enough food or if you do not have decent housing? They are smart enough to know, without however many years of education it takes us to conceptualize the fact, that the basic health-sustaining resources are such things as food and housing, which consistent and adequate income make possible. Since they are never certain that they are going to have those fundamentals of health, health services do indeed seem to be a luxury, to be thought of later. You can only think of them first when the fundamental priorities are so routine as to not enter your consciousness anymore. You just assume those fundamentals are always going to be there and for many people that is realistic. The more educated people are also the most affluent, and it is then at that level to start talking about health services and other sorts of fancier ways of dealing with health.

When we talk about health care, it is important to note that what we know is not what we do, and what we do is related to the choices available to us. If you look at a supermarket in the ghetto, the easiest choices may not always be the most healthful choices, but even more important, when you have few dollars to spend and you do not know if you are going to have those few in a few days, the easiest thing to do is to spend the dollar where you think you are going to get the biggest kick. And that is very human. Probably the affluent person thinks the same way, and consumes excessive calories, which are easy to get and which can give them pleasure. With the dollars available and the choices available, they both go for the easiest thing and the thing that is perceived as the most pleasurable for now. But because there is so much abundance for the affluent on the one hand, you get the fundamental foods plus a lot of excess. And on the other hand among the poor, you have so little that you just take the things that seem tastiest for now.

We need to take these factors into account in thinking about changing patterns of behavior, not so much by telling people what is good for them, but by simply making the more healthful choices easier. People do what is most convenient and easiest. Very often in our society, the easiest thing to do - the most convenient - is

often more health damaging than health sustaining.

This concept is being applied in Sweden where they are going to make it very inconvenient, very difficult for people to smoke. You can smoke if you would like to, but they will not make it easy. So the whole pattern of that sort of habit will be changed in Sweden. We have done really very little to make smoking difficult for people. It is often more difficult for the non-smokers.

The central city population is proportionately more Black or other minority races. It is also older compared to the suburbs; we think of the central city as having a lot of kids, which they do, but there are relatively fewer under age six than in the suburbs, and there is a greater proportion of people over age sixty-five than in the suburbs. There are fewer family households and more combinations of unrelated individuals in the central cities. There are more women-headed households, and more people with an income of under $5,000. More of those people are Black. More of those people are women. More people are on public assistance; there are more women working; there is more unemployment and more dilapidated housing. With inflation the burden is placed disproportionately on lower income people who spend a larger proportion of their budget on the basics of health: the food, housing and clothing. They have less then for anything else and yet their federal income taxes and social security taxes are almost as much, proportionately, as a higher income person, and their medical costs are more as a proportion of their budget. So their situation becomes increasingly worse in this inflationary economy.

To summarize, the people of the central cities have fewer health-sustaining resources and fewer of the essentials for health: food, housing, clothing, job and steady income. And so we, or I, characterize them as outcasts, in terms of having less than the majority in our society. And always, outcast or disadvantaged groups have a greater proportion of minorities, particularly Blacks, more older people, and more women.

In regard to mental health, it is conceivable that those who have severe mental illness problems tend to gravitate to the poorest areas of the city, which would be the inner city, and maybe that is why you have more schizophrenics there; this has nothing to do with the population itself as we have described it. A second point relates to the "labeling" of people. People like us who have been to college and who know what mental illness is and how you are supposed to answer the questions to show that you are more mentally healthy than not, always answer those questions better, so we seem to be more mentally healthy. People who haven't been to school do not do

as well on these tests, and therefore are labeled mentally ill or mentally retarded. Furthermore, what we may call mental illness may be really just the normal human reactions to the terrible conditions that some people have to live under.

It is an interesting irony that the rate of chronic disease is higher among poor people than it is among the affluent people. When poor people have acute conditions, those illnesses are more disabling. They are more likely to die from those acute conditions (particularly the most vulnerable age groups: the aged and the babies and the pregnant mothers in delivery) especially conditions having to do with respiratory and gastrointestinal infections and certain types of injuries and accidents. But they have more chronic disease as well, and their disability from chronic diseases is more severe. The way to understand that is fairly logical. Because they have fewer health-sustaining resources, they get both acute and chronic conditions, and those conditions hit them harder. If you are affluent, you can get a condition treated or you can move yourself to a more comfortable environment; you can take a day off work, and you have fringe benefits and you do not have to worry. If you are poor, you are lucky if you have any kind of a job, you do not dare take a day off, you do not dare rest, you do not dare take time off to go where the air is cleaner, even if you can get there easily. So your symptoms and problems build up.

The interesting thing about this is that because the poor have the disease picture that they do, they are often more treatable than the affluent. That is to say, if you get disability from the kinds of acute conditions that poor people have: the infections and the injuries, those are the kinds of things for which medical services have some kind of treatment; whereas for some other problems, there is not much in the way of treatment. That is, the chronic disease picture has very little that can be done to really make it go away.

To illustrate this in terms of this question of who: we know that the infants of the poor die two to three times faster from a number of conditions than the infants of the more affluent. The things they die from more often are the gastrointestinal and respiratory conditions as well as low birth weight. We also know that the poorer women and particularly Black women are less well-nourished than their more affluent and White counterparts, and that condition plus an insufficient weight gain during pregnancy, which relates obviously to food intake, is what principally produces the low birth weight, the premature births. And low birth weight is the leading cause of death in the first month of life. The leading cause of death after the first month but still within the first year is the infections that the babies get. And they are predisposed

to those infections because of a general undernutrition. So, what we are saying is that the poor are less protected because they are less well-nourished. The environment hits the poor harder, disables them more and increases the risk of death.

Not only are poor women more likely to give birth to the low birth weight babies, but they also have two to three times as much maternal mortality from things like toxemia which is related to their nutrition, and they die more often of infections and hemorrhage from the delivery process postpartum. A lot of the hemorrhage and infection to date have been caused by bad abortion procedures. Poor women often have to go in to illegal kinds of situations to get abortions, and those are terrible delivery situations. That is where they have gotten their infections and hemorrhages, without blood plasma and other services available. So, that's basically the source of maternal mortality among the poor.

If you look at the adult death rates of the affluent and the poor, you find that more of the poor die from such things as pneumonia, diabetes and accidents, particularly accidents due to violence, and you can see how this is all related to the kind of conditions in which they live. This difference in the picture of health and illness among the poor and the affluent shows us that some kinds of ills that the poor have are treatable. There is no reason for anybody to die of pneumonia and diabetes today. These are diseases that we thought were taken care of in the past. There is no reason for children to die of infection and respiratory problems. There is no reason for women to die in childbirth.

So the indicators of health that we can use are: death rates, and it is always important to look at the income group and the racial group; and, the incidence of acute conditions and chronic conditions; who has them and where? These data are now available regularly, annually, and they are based on national random samples. Now I think it is curious, not to say ironic, that we don't know much about what is physiologically normal. But we are beginning to put some of this picture together. We know what is the range for vision, teeth, height, weight and blood composition in part. What is normal and what is illness? We do not really know very much, but we do know that even in the statistically normal range, poor people do not have as acute hearing as more affluent people. We cannot say they have a hearing problem, but they do not hear as well as affluent people. The same with vision. The same with body composition: they are smaller, they often do not weigh enough.

We have read many times how poor people have as many physician visits per year as the non-poor. As another very recent study pointed out, in relation to the kinds of disability that they have, the poor are still getting less medical care. In other words, if an affluent person has four and one-half visits to a doctor per year, that is one thing, but if a poor person has four and one-half visits a year, in order to equate those, you have to take into account how much disability those two people have. Since the poor have greater disability, the poor are receiving less in relation to what they need.

If you talk about access to comprehensive services or primary care services or home health services or any other facet of health services, what you find is that the distance the poor people have to travel is greater. The amount of time they have to wait is longer, both in the facility and for appointments. So their access is not equivalent to people who are not poor.

We have characterized the central city population. We have looked at some of the indicators of their health and lack of it. We recognize that they have relatively fewer health-sustaining resources so they are more vulnerable to damage; they also have fewer health-repairing resources so they are more vulnerable to more severe damage and to death. But let us say for the sake of argument that we could put health services into the central cities without worrying about money and resources; we can put everything in there we want in the way of health services. What will that do to the health of people in the central cities? Let's say we are going to provide humane health services so that people would not be impersonally treated; they would not have to wait, located right in their neighborhood, and we would have all kinds of services there that people would want, so that people are going to use them: comprehensive personal health services - the best - the same kind of health services that are available to affluent people. Then, for example, if prenatal care is made available, what impact will it have? The answer is that recent studies of prenatal services show that by and large they make no difference. If you look at the major causes of death in infants, whether in the first month of life which has to do principally with things that revolve around low birth weight, or the next eleven months of life, taken together, those all have to do with the adequacy in terms of amount and kind of food that mother and baby get. Now, if that prenatal care includes a guaranteed diet from preadolescence to menopause, then it might make a difference. But most prenatal care does not include that. Now people in maternal and child health will show you dozens of studies that show that the more prenatal care, the lower the prematurity rate. However, there have been studies done of those studies, and

what they show is that the only reason the babies were full-term and the mothers had more prenatal care was that the gestation period was longer so they had more physician visits, while the mothers that had premature infants naturally had less than a nine-month pregnancy, so they had fewer visits to the doctor. It was an artifact of the way they were tallying up the number of visits, and it had nothing to do with prenatal care.

There are no medically based studies to show that you must start prenatal care at this point and have one visit a month and then one every two weeks and then one every week and so on. That is not based on anything except custom and habit. The only exception might be where the mother has a previous medical condition, but that medical condition would need to be treated anyway.

The question is: which particular health services have an impact on health and how much of health services have a positive impact on health? Recent studies are beginning to show either the zero or negative or very limited positive impact of many facets of health services. I do not know of any evidence that primary health services really make any difference as far as changing people's behavior and the kinds of things that they choose to do that will impact on their health. And so, I suggest that if health education is to have an impact it will have to be tied to a new range of choices for people.

Education does not change our patterns of behavior. It is, rather, knowing plus having options for action available to us, and it is those options that have to do with policy. It is policy that sets up alternative options and by and large, the kinds of policy we have in this country give us not very health-sustaining types of alternatives. In fact, the easiest choices are basically health damaging, whether it is the range of food on the supermarket shelves, the types of transportation that we can use, or the types of housing.

Health resources ought to be allocated by and large to poor people. Affluent women really do not need much, for example, in prenatal care. They might need an initial screening, but not much more. The baby can be born at home and in most cases everything would be fine. In the Netherlands, they have the lowest infant mortality in the world, and half the babies are born at home without the physician present. Birth is really a normal process. I am not saying that nobody should have prenatal care. I am saying that it needs to be looked at and defined in a much different way than exists now. The whole business of thirteen or fourteen visits is extravagant, and has no basis in medical or health necessity at

all. It rather has a basis in the high incomes of obstetricians, ninety-six percent of whom are men, and more than that of whom are White.

Look at pediatric services. We know that about seventy or eighty percent of the practice of a pediatrician is composed of normal children. And the only definitive thing he can do, probably, is to give immunizations and maybe an antibiotic if he uses the right one at the right time for children who have certain kinds of infection. Often the infections, particularly those that poor kids have, are not responsive to antibiotics. Also, many times the drugs they get mask the symptoms that they have. Actually an important cause of injury in children is the adverse reactions to drugs and treatment.

One preventive service, if again it were a matter of individual choice, is the prevention of unwanted births, which can preserve the physiological strength of women and avoid some proportion of premature babies. It can also broaden family options as to their life-style. But if we were to list the measurable impact that particular health services can have on health, all we could list would be things like contraception, immunizations, selective antibiotics, excisions of tumors, certain amounts of decreased discomfort and pain and disability, and very selective screening for treatable diseases. Also, in prenatal care, if you have a mother who has a urine infection and you treat it, you can prevent an adverse impact on her and particularly on her baby. A urine infection or a sub-acute infection otherwise need not be treated and so need not be screened.

If health services were conceived as a system which was expected both to prevent and treat the current picture of illness and unwanted deaths in our society, the contemporary illness profile, then we would be doing different things, would we not? What we call health services today is the result of various kinds of decisions in the past. But there is almost no way, no institutional or organizational mechanism, through which those of us in various facets of health services can do anything to change the array of options that people have in terms of the conditions under which they live, which are really the things that are making them ill or healthy. All we can do, we say, is to try to do the best we can delivering the services that are available and making sure that the poor people as well as the affluent people have access to those services. But we never ask the question: are these services really going to make that much difference? Because health services have become so specialized and so broken off from the basic social conditions under

which people live, we can only think in terms of our compartmentalized experience and training. So it is very difficult even to ask the questions. And when you ask them and get really very strange answers, it takes time to think them through: now how can this be? You mean so much of what I've been thinking is not so? What's wrong with me? I'm really not that dumb; I've kept up to date, and so on and so forth. Things are changing, and we need to find new eyes to look at them.

The Effects of Public Policy on Outcasts

by Nancy Milio, R.N., Ph.D.

What I thought of doing for today is to look at the more direct health related legislation that has occurred in recent years and the legislation that is in the Congress now. First, looking at what policy threads run through the legislation that has been coming and is coming, and then making some general assessments as to what current and proposed policy direction is likely to do for people's health and for health services. This I will do, particularly again, in relation to what I have called, outcast groups, which always, in my mind, include people who are poor; people who are in racial minorities, particularly Blacks; people over age sixty-five; women; and people who live in the inner city and the rural areas. If you look at any figures, these people are basically on the bottom when you compare them with their counterparts, so we're talking about large groups of people.

As far as policy making is concerned, we have no mechanism for developing or evaluating policy with respect to health. Nor do we have a policy mechanism for health services - a single policy mechanism. Now what we have, of course, are many vehicles which evolve policy and implement it - some public, some private, some profit-making, some non-profit-making. But because there are so many vehicles located at so many levels, national to local, the policy is not necessarily coordinated. There are some who say that a lot of people or a lot of groups like it this way because, of course, you can influence policy at a lower level much easier than you can where policy development is put together at a larger level. So, what we come out with is some often contradictory policies, and a policy development process which is manipulable by whichever groups can get the ear to the policy-makers easiest. Of course, the groups that can do that best always are those who have money to do so, staff, time, etc.

In recent years, we have had an increasing amount of legislation that has to do with controls over health services. PSRO is the big issue now; a little earlier, utilization review and Section 1122 of the Social Security Amendments which amounted to a national certification of need legislation. The important thing, it seems to me, in that kind of legislation

is the increasing effort to get at some kind of cost control, relating this to trying to do away with unnecessary services, unnecessary facilities. In order to do that, of course, we need to find ways to measure what is necessary, and so there has been a great deal of interest in how do we know what we need or what we do not need and what is effective and what is not. Consequently, there has been more and more interest in finding measurable indicators of health and necessary health services.

Then in a somewhat different vein is legislation which has to do with the environment in the ecological sense. The Occupational Safety and Health Act is a very good piece of legislation, not to mention the Air and Water pollution control legislation. What they do which is new, relatively new, or a new direction, is to define the environmental concerns of health services more broadly than in the past. As a result, there is much more money going into environmental concerns, and the legislation also puts some teeth, finally, into that kind of concern so that the consumers - in this case, people in their workplaces - have a mechanism for having input into the basic conditions under which they work. Here we have consumer participation in the environment of the workplace, which is so directly related to the health of people, who are there at least a third of the day.

This concern about environment in a somewhat broader definition of the environment relevant to the care of health, is what I've noticed in new health services legislation - the proposed Health Services Act. What it does, at least in terms of migrant health centers, is to say that these migrant health centers are to be concerned not only with the delivery of services, but also they would have means to deal with problems of the pesticides that might harm migrant workers, rodent control, housing, accident prevention, and any other conditions which impinge on the health of the people, essentially the migrants, who would use this kind of health center. It's really quite beyond not only what neighborhood health centers have been thought to be their purview, but beyond the traditional environmental health programs that have been part of health departments for so long - getting into the living conditions, the living situation of the people, and tying their personal health services to some extent with the conditions under which people live. This is a new thing - this actual organizational tie between personal health services and the care of the environment in which people live.

Another important inclusion, which again is new this year, in the proposed veneral disease prevention and control act and in the disease control act, is the idea of defining disease control as not just communicable disease anymore, but non-communicable diseases or diseases that we might say are epidemic or perhaps endemic in an affluent society. In this case particularly, say, diabetes or high blood pressure would fall under this definition. Again, this changing of the definition of disease control goes beyond the notion of communicable disease, which was important in a society of the past, but does not significantly affect major parts of the population today in the same way that it did. This, among some other things, has been quite heartily opposed by the AMA because they say, that that then opens the door to try to control all kinds of diseases and no longer leaves the job of control in the hands of the family physician who attends to our health needs.

These are new threads, but I wouldn't want to make a bet that this legislation will pass this Congress. However, these kinds of proposals have been coming more and more often, and I do not think they are going to disappear. They may be passed in such a way that they become rather bland, but I think they will continue to mount and eventually and in part, will be passed.

Then there is the legislation having to do with education and information - health education information - but in somewhat different contexts than traditional health education. Certain proposals have to do with pre-schools, where the emphasis is to be on the health and nutrition and basic education of the children, rather than just caretaking or just reading, writing, and arithmetic. In other words, they try to incorporate information into early life habits, in a setting in which the children are going to spend sufficient amounts of time to practice these habits and receive a collective, group approval and teacher approval. Along with this is the idea of providing comprehensive school health education beginning from kindergarten on through the entire basic education of people, in an integrated fashion. This bill provides monies not only for curriculum development but for a whole series of faculty development programs so that there is time, money and people to help faculty not only learn the concepts but learn together how to integrate that content into the ordinary educational process.

Then there is the National Health Planning and Resources Development Act, setting up Health Systems Agencies. It in effect combines what the Comprehensive Health Planning agencies,

the Regional Medical Program, and the Hill-Burton organizations were all supposed to do but did not have enough money or teeth to do. This Health Services Agency which is an area-wide, mandated organization with at least fifty-one percent consumers on the policy-making board is supposed to integrate services regionally and is supposed to develop primary ambulatory care in a cost effective way, and is supposed to do all the things that we would like to have done. It is important not just for now but because it will probably be the mechanism that will have a great deal to do with national health insurance dollars when that program happens.

One of the differences between the past and the present is not only that these agencies no longer have to rely on local contributions from hospitals and insurance companies - which helped to move decisions in favor of these organizations - they now get their funds through federal dollars and they also have an extra fund to help give an incentive for developing programs that are needed within the region.

One other thing that is new and important is that presumably these Health Systems Agencies would be evaluated on the basis of whether or not they improve the health of the people in their region. That is really new. Health agencies have never been evaluated on that basis. They also have the possibility administratively and otherwise of uniting with environmental health agencies, which might become a productive link between personal health services organization and delivery, and the care of at least the ecological environment.

The Health Maintenance Organization legislation and its regulations are fairly recent and provide that services be defined by two types of people: by medical groups and by "other health professionals." "Other health professionals" are listed as: dentists, nurses, podiatrists, optometrists, physician assistants, psychologists, social workers, pharmacists, nutritionists, occupation-physical therapists and other licensed personnel who have been institutionally licensed, certified or under the supervision of a physician or other authority. Now, that is really very broad. If under the regulations, HMO's will get paid for the services that they deliver by the medical group and "other professionals," namely, everybody else that's under an HMO, that really poses tremendous scope and flexibility and maybe some problems as well. But it really has implications for the kinds of training and certification that health personnel are going to need in the future if, in fact, this mode of delivery really develops under, say, national health insurance.

Another important thing in the regulations, I think, is that for every enrollee in the HMO, there will be a health professional, under this definition, who is primarily responsible for coordinating the overall care of that enrollee. Of course, this then means that anyone of these people who work in this place now will be the primary care coordinator, if not care giver, for the members of the HMO. That gives really far greater importance to all of the kinds of personnel in the HMO. This then means that all of these people in an HMO are potentially sources of income for the HMO; therefore, if their services bring income to the HMO, their wages are not going to be, I think, as relatively low as they are now compared to the top-paid people. And if their salary scales do not have this big gap between the top and the bottom, then more types of personnel are potentially going to be more important in terms of what they say about what goes on in that HMO. Further, in a more obvious sense, HMO does have provisions for grievance procedures, not only between consumers and the HMO, but by the personnel who are working in the HMO. You can see that the whole internal decision-making structure has here potential for really changing, to make it far different from what has been traditional in the delivery of health services.

The way that this would affect what I would call "outcasts" becomes very clear. Until now - if we look at the pyramid of the health occupations, four and one-half million personnel from top to bottom - as you go down the pyramid looking at the various types from doctors at the top to aides at the bottom, you have greater proportions of women, greater proportions of minorities, greater proportions of people who come from lower income groups and who end up at a lower income because they're paid less. As you go down the pyramid, also of course, there are fewer and fewer possibilities for people to move up. Personnel groups range from those holding high collegiate degrees to other kinds of certification to no certification. So those on lower ranges must stay, more or less, at or near the bottom. I suggest that if the delivery of services measurably changes in the way that these regulations suggest that they could, and if the HMO becomes a prevalent form of delivery then this pyramid could no longer exist as it does now, because the people who are now on the bottom rungs or down the line will become financially more important to the delivery system. Therefore, they will be paid more; they will have more to say; and we won't be able to afford this elite at the top in the way that is possible now.

Then there are a couple of other things in the regulations that I think are important in terms of shifting the kinds of services that are available, and this has to do with home care.

It is really a little bit paradoxical to say, on the one hand, "yes, we must move out of in-patient facilities the patients who don't need to be there." But you can not move them out unless there is an alternative. Part of the alternative, of course, is to do more on an ambulatory basis. That is fine. But, there are categories of people who can not be taken care of simply on an ambulatory basis. These range all the way from normal babies in childbirth to terminally ill patients, and everything in between, including young people who have had bad accidents to people who are being rehabilitated, people who have mental problems, to the people who are just old and can not move around very well or the handicapped. The alternative with least cost as far as the system is concerned, and the most humane, I think, as far as people are concerned, is to be able to be cared for within their living situation: the home. But you can not do that unless you put money into home care programs.

The HMO must now make this service available. As it is defined at present, it is quite narrow. But I think one opening here is the fact that home care can be prescribed by the physician or "other persons who are authorized by the HMO", and that means anybody else in there. If you have other people who are oriented in this way and who will take the time to start thinking in these terms, more than physicians traditionally have done, then I think we will use this option more. As long as the HMO is paid for this kind of service, we will see more of this service made available. There is also, for the first time, legislation in the Congress proposing monies for the initial startup and development of these home care services. This has never happened before, and once there is money to start developing these kinds of programs, then they become an option.

One other point about home care and regulations is that (and this was so altered after the initial regulations) the HMO is not required to use the existing home health agency in its vicinity. It may develop its own home health program. What does that mean? If you project the notion of HMO's becoming a more prevalent form of delivery, their main source of funds right now is increasingly Medicare and Medicaid, and so if national health insurance dollars are diverted through HMO's into their own home health agencies, there will be no funds left to run the current Visiting Nurse Associations and home health services. It seems that for one reason or another, the experience of HMO's so far, has not been very good in working with the existing home health agencies, and the problem is probably on both sides. I think it is a warning to people who

are in home health agencies now, that they are going to disappear unless they start linking with comprehensive ambulatory care facilities.

There is also the legislation on health personnel. Right now, we are down to two types of legislation. It will not be too long before there is just one. The tone for the legislation, I think, was set in the last report by the National Academy of Sciences Institute of Medicine that was commissioned by the Congress to do the study of the health professional and health professions education in the United States in the last couple of years. The conclusion of the report was (and it's a two-edged sword, I suppose) that the health professions' schools are a national resource like Yellowstone National Park. What does that mean? On the one hand, it means that if they are a national resource, we must take care of them. That means they have the full right to taxes for their support. We are really talking about medical schools. That is one side of the coin.

The other side of the coin is that if they are a national resource and supported by tax dollars, then there is going to have to be some justification made for them at least, to some extent in the name of the public interest. That means that if medical schools are to receive more and more tax dollars, they already receive more than half their budget from the tax dollars that they are going to have to direct themselves to some extent toward the public interest in terms of producing the kinds of personnel that are relevant to the kinds of health service needs that exist in the country today.

The other important thing, I think, in the report is that it says the education of health professionals is fragmented and needs to be at least coordinated; so many sources of funding, going in many directions, and the left hand doesn't know what the right hand is doing. Literally, nobody knows. They really could not come out with very clear estimates on education costs because the records, the definitions, everything is in such disarray. The legislation on now is going to try to make that situation a little more coherent.

Additional proposals include such things as the fact that students - all students who are covered by the health manpower act (that means the seven health professions as they are defined by the U.S. Government doctors, dentists, optometrists, podiatrists, osteopaths, and pharmacy students, veterinary medicine) plus the people in schools of public health, plus for the first time health administration students, plus the allied

health professionals - all would have responsibility for pay-back of capitation funds that the schools receive; not that they, the students, receive but that the schools receive for them. They would either pay back in dollars or they pay back in service on a year by year basis. Service where they are needed. Service in scarcity areas, underserved areas. In addition, there is provision finally for some control over the development of specialities in medicine so that by 1977 they would have to start dropping the percentage of specialty residency positions that are available. In other words, if a residency position is not approved as needed, within a certain number of positions that are deemed requisite in a given year, then the hospital will not get the monies to pay for the resident, and so they will not have a resident in that particular specialty. This will start to reduce the proliferation of specialties in medicine, which are very high in cost and seem to be superfluous. All of this is part of an effort to redistribute personnel, both geographically and by type and to try to develop more primary care-type personnel, from the physicians through the whole pyramid, and to consolidate the planning of how many of what sorts of personnel are needed.

One other thing to mention is that there is much stronger encouragement, let us say, a push toward inter-disciplinary kinds of education for these myriad health professionals. This education would encourage health practitioners be trained in the financing and organization of delivery, evaluation of services, and the efficacy of treatment.

If you look at all of this legislation, there are certain policy threads that reflect an effort to move the system of health services into some kind of coherence. We are moving toward national standards: standards for financing and delivery; efforts toward trying to disburse and redistribute some of the personnel; toward planning and more firm controls so that planning goals can be carried out; to date, they have not been able to be carried out. We are trying really to stop the sort of free-for-all that has existed for so long. We are trying to move the emphasis toward the kinds of service that are most needed by most people most of the time.

Decision-Making in the Health Care System

by Nancy Milio, R.N., Ph.D.

By way of summary of the last couple of days, I have been trying to look at how health policy affects both health and health services. In the direct sense, policy influences the health impacts of the environment in which we live, the kinds of health-sustaining resources available. In the indirect sense it influences the distribution of health-sustaining resources: Who has access to the conditions for health? Who has access to the best kinds of food and housing? Health policy also affects the resources for repair, or health services that repair the damage done by deficiencies or excesses in the environment. Again, it affects directly what kinds of health services are available. In a less direct sense, it shapes the distribution problem: Who has access to those services?

Our discussion yesterday pertained to health legislation and concentrated mainly on this problem or issue of access to services, as well as, to some extent, the kinds of services that are available. The effects on health and on access to health services of these policies in many respects has not been the optimum and often has been negative, but not because the people who initiated the policy or the programs intended it that way. The notion of intent and effect, again, should be distinguished. People who started certain kinds of programs, including people who started hospitals, did not necessarily intend to contribute to the effects that overhospitalization and over-built hospital facilities have had as far as the system is concerned, nor to what this has meant to particular parts of the population.

The question today is: Why have these kinds of policy decisions been made rather than some others, especially if it seems so obvious now that some of the impacts have been negative or ineffectual. It seems to me that in order to answer that question, we have to at least look at what is the source of the policies: who makes the policy, how is it made, as well as why the decisions were made as they were. Using the context and frame of reference of the national setting, let us look at policy-making as it exists in the federal government. First, take the process of legislation which is introduced, through either the Congressmen, the administration, the

White House bureaucracy, or the other bureaucracies. There are the Congressmen and their staffs, and the whole committee structure of the House and Senate. There are sixty-nine committees that deal with health-related legislation (health by conventional definition). This is a very complicated array of entities, all of which write legislation, have hearings, and get inputs from all sources. Of course, at this level, there are many groups that talk to Congressmen, help get them elected, talk to their staffs before the legislation is written. They testify at hearings on legislation. There are all sorts of constituencies in HEW from each bureau that say, "This is what we need, and this is what policy should be." There is really nc coherent structure that can pull all these pieces together.

In trying to examine where a policy came from, in trying to explain why it was chosen, and what can be done about it, we can break down the process into a number of questions to find out the source of the policy. We start by determining who is framing the issue. Who is defining the question? Obviously in asking the question or defining the issue, we are making certain assumptions already. It makes a big difference as to what policy is ultimately chosen if we pose the issue as, "Do we need more physicians?" or "How can we develop more physicians? We want to improve health care. So how can we have more physicians?" Is that the issue? Or is it, "How can we develop and use more primary care practitioners?" Or another way to frame the issue is, "How do we promote access to primary medical care?" Obviously, in asking those questions in those ways or in any number of other ways at the outset, the answer will be biased. So, the first question to answer is: Who is shaping the question that is going to be a policy issue?

The second question is: What are the channels of communication in this process, that is, where does the input come from in formulating this issue? Which groups, in which ways: informal ways? formal ways? What kinds of networks exist where information flows back and forth in formulating this issue? Also, how are the criteria for choosing among alternatives formulated? Are we going to have economic criteria so that the information that gets fed in implies finding the cheapest method? Are we going to have criteria that have to do with equity? Who is developing those criteria? Who is really going to make the decision? Is it going to be at the Congressional level? Is it going to be an administrator in the executive arm, or at a different level? Is it going to be the administrator of a hospital or is it going to be the board of a hospital that makes this kind of policy decision? This is important in understanding the source of policy.

After the decision is made, how is it implemented? For example, we were talking about HMO implementation yesterday. We know there are many good pieces of legislation that have been passed for a decade. The way in which legislation is implemented is as important as the legislation itself, if not more so. All the regulations in themselves are questions that are posed, and they can change the shape of the policy. In that respect, this is another question: Who is setting the criteria for evaluation? In other words, what kind of feedback after implementation are we looking for? Is it going to be whether or not people like it, or, whether the people who like it - voters, the supporters, - can pay out of pocket. Do the criteria also include whether the particular program or policy as implemented has a positive impact on people's health, whether it is cost-effective, whether it is replicable. Once the evaluation data or the feedback gets to the policy-makers, what is done with it? Which of the feedback gets excluded automatically? Which data is fed back into re-formulating policy? Is attention paid to it at all? And through all this, what are those channels that are making this thing go around? It is really a kind of a cycle of decisions, and at any point, the people who have access to this cycle are the ones who are organized. In order to be organized, it is necessary to have money, to have the right kinds of contacts, to have the information that you pass into the network, and to have access to information before other people get it. Then a group can begin to influence the shape of the policy that is formulated.

Those are some questions that I think are important in looking at the source of policy and trying to understand it and why we have what we have. Also, in looking at this kind of decision-making, there is a lot of confusion which results because people don't specify what context they are talking about. I started with the national context, but then we might be talking about the context of a particular organization or of a bureau within an organization, or a department within a school. We have to specify the level at which we are looking for the source of policy so at least it is clear at that level. Then we have to look at what is the level above and how did the decisions of the level above affect the decisions on the levels below and go on up the hierarchy.

The "Why" of policy, that is, why does a department or any policy-making body make one decision in contrast to another at any of these points in this cycle of policy-making, can be answered. Every group or organization is going to be making decisions on the basis of whether or not the group can, out of this decision, first, acquire or maintain at least the resources that it has for its

survival; or acquire more resources to either ensure its survival or its growth, preferably its growth. That is the first rule of life of any organization: to survive. This explanation is not too far beneath the surface as to why some policy-making board or body decides to do one thing or another. First, they always say, "Well, we just have to have enough money to keep going before we take on these reforms or innovations you want us to." You heard President Ford a couple of days ago, saying in effect to the NAACP that, "As long as we have an inflationary economy, there is no chance for anything and if you want your chance, you've got to let us deal with the inflation, and then you can have your piece of pie." The rationalization of survival first is the something that every organization goes after, and this survival is its primary criterion for decision-making, almost all of the time regardless of its stated purpose. However - and it is not as simple as it seems - we may find that in a policy-making situation or when a decision has to be made about whether an organization undertakes this or that program, and there is this implicit, if not explicit, calculation of what is this going to net us, it might not mean that the organization is going to have an increase in revenues right now. What it might mean is that if the organization goes along in this decision, at some point six months later or next year, it may get a chance at larger funds, thus enhancing its future bargaining potential if it will go along with a certain decision now. This kind of bargaining goes on.

It took me, I'm sorry to say, at least months, if not years, to wake up to the political reality of the world. I first began to see the reality of politics when the health and day care center in Detroit was first getting started. We had promised to have a family planning program. We managed to get the Planned Parenthood League to agree to furnish the services, but they said, "We can't have unmarried girls getting contraceptives." Of course, we were in a community where there was a large number of teenage girls, and they were getting pregnant. Their mothers, as well as themselves, were interested, at least to some extent, in having access to family planning. So I talked to the executive director of the League, and I asked, "Why?". She said, "Well, it's immoral. We would be promoting immorality if we gave family planning to unmarried women, not just teenagers, unmarried women." She had really not talked about morality before, and she said, "Our board just wouldn't stand for it." The Family Planning League at that point in time was run by a quite affluent board of people from the suburbs who were responsible for bringing in the vast majority, if not virtually all, of the financing of the Planned Parenthood clinics. There were no other sources of funds. There were no public sources of funds for

family planning, and therefore, if the board said it was immoral, then the director had to say it was immoral. If she did not reflect the board, then she would lose its support and the agency would disappear.

At about this time just before the middle '60s, United Foundation fund agencies and similar privately donated funds were running into trouble. Costs were going up; they were never quite able to make their goal each year, so they were having trouble as it was in meeting their budget. They couldn't afford to do anything to make their contributors unhappy. Just a matter of a couple of months later, the OEO had acquired under its purview, funds for family planning. Because the Planned Parenthood League was associated with our neighborhood health center, we could get access to federal dollars for family planning, which then would go to the Planned Parenthood League. One of the requirements for using those OEO dollars in family planning was that there should be no discrimination on the basis of age, marital status, or otherwise. All of a sudden, the Planned Parenthood Association said, "Of course, we will give family planning to anybody who seeks it." For minors, we required some indication of parental consent, but whether or not they were married no longer made a difference. This was posted on the clinic wall, and the director never mentioned morality again. The point is that it is a matter of survival and a chance for resources that is important. This is the crux of policy decision and not rationalizations about moral judgments. What will allow the organization to survive and hopefully to expand is the important issue. For a planned parenthood organization to be able to use federal dollars was critical because the federal dollars were going to be expanding as private donations to almost all service organizations were beginning to contract. If Planned Parenthood could get federal dollars, they would not have to rely on private donations totally as they had in the past. This was the source of resources that Planned Parenthood wanted, and they adjusted their policy accordingly.

The other qualifier that we need to keep in mind is that even though organizations try to enhance their resources in the present, or their future bargaining power for getting resources, the decision is not always based on all possible information. The perspective is limited. The sources of information might not be totally accurate as to what the chances are for really enhancing resources in a situation or resulting from a given decision. It is not a perfect decision in the sense that it cannot be totally reliant on hard data or hard information. It is the best possible guess of the people who are making the decisions. They would make the decision that would be most likely to sustain them now and in the future.

As I mentioned, we should keep in mind especially today, that the range of options for an organization in making decisions about retaining its resources are more and more set in a hierarchical fashion, starting with federal dollars. The range of possibilities are set out by the kinds of federal dollars that are now available and for what purposes. The effects ramify to the lower levels. For instance, the shape of home health agencies today is very much a reflection of federal regulations now, whereas, about ten to fifteen years ago, the shape of those home health agencies was very much a reflection of their source of income at that time, which was totally local and from private donors. If they wanted to survive and grow, they had to shape their programs according to federal regulations which said, "If you don't do thus and so, you don't get these dollars." They needed the dollars, so they did those things and the organizations look different today than they did then.

Likewise, what happens inside organizations depends on the major income sources of the organization from the outside, whether they get their income from regional groups, from the federal government, from private industrial groups, or from private non-profit groups. Whatever those income sources prefer determines the shape of the program. This makes a difference, then, as to what an administrator can do within the organization. For instance, not very long ago, the pay of resident physicians in hospitals was very low, and the residents unionized and fought to get more pay. They were quite unsuccessful at first because, in order for them to be paid more, hospitals, of course, would have to get those dollars from somewhere else. The hospital wouldn't be very likely to get the dollars from already low-paid other staff people; they would pretty much have to take those dollars from either facilities funds or new equipment funds, the sorts of things doctors like. The hospitals were not about to be doing things that doctors didn't like, since that is important in the hospital's image and in their ability to get other dollars. Then Medicaid started paying for the services that were rendered by residents to patients, and this was a whole new source of money for hospitals. Therefore, residents were able to get a fairly decent salary. It seemed they were able to bargain for a better salary, but the only reason they were able to do so was because the option was available to the hospital to get a new source of money. The hospitals, because of their own other bargaining requirements, were not willing to take that money from other funds within the institution. When they found a new source of money, they then passed it on to the residents, and it seemed that the unionizing of the residents was the factor that won them higher wages. I think the same becomes true for any group within the various kinds of organizations.

At one point early in the '60s when the Maternity and Infant Care program was to be started, the intent of the legislation was - and at first even the regulations stated - that these maternity and infant care clinics were supposed to be in ghetto areas and areas where poor women lived. This was supposed to be an outreach program; to give prenatal care to every poor woman who needed it. The universities were supposed to be involved, lending their expertise in obstetrics to this effort. But the university faculty were not willing to go into those ghetto areas. So the regulations were changed so that the M & I centers very often became attached to medical centers, and the poor women had to go to the medical centers to get their care from the specialists that were associated with the university medical centers.

Just a few years later when the neighborhood health center legislation was to be implemented, some universities actually started neighborhood health centers away from the university. It seems to be a paradox that they weren't willing to move outside the university walls in 1962, but starting in 1967 and 1968, they were willing. What was it that changed their minds? I think one of the things that changed their minds was the fact that around 1966 Medicaid came in with the stipulation that poor people could go to any medical resource they wanted in order to get treated, even private physicians. In other words, poor people didn't have to go to medical centers any more to get treated. They could go to their neighborhood physician and be assured that he would get paid. All of a sudden the university medical schools saw that they were going to lose the patients for their medical students. Then they had to move out and go where the people were in order to have "teaching" material for their students, and so they went. This was not necessarily an ideological change.

I would like to qualify my statements by acknowledging that I am sure that the people who started these programs were well-intentioned. I know that many of the people that initially worked in the neighborhood health centers or even those who persist today were the ones that were reflecting their own thinking rather than the kind of policy overtones that I am suggesting here about resources for the university. Not every individual is involved. But this <u>is</u> the nature of <u>organizational</u> decisions and of the calculations involved.

I have not mentioned power at all. In the context of developing policy and making the decisions that develop or implement policy and who can do it effectively, you could say that power is the capacity to bargain effectively. Bargaining effectively simply means that within any given decision-making situation, if you come

out of it with more resources than when you went in, or with the potential to get more resources, then you are powerful in that situation or more powerful than the group on the other side. If we want to project that on our discussion yesterday of the various approaches to national health insurance and which groups are proposing which ways to shape it, we see that the reason a group proposes things one way, is because if it is done their way, their organization, their group - the insurers, the hospitals, the private physicians, - is going to come out with at least as many resources as they have now and probably more. We could explain the same thing in terms of the Health Security Act. Why did the unions support it as compared to another? Why do the university physicians support it instead of one of the others? The answers are too difficult to figure out.

Finally, if we use the rule of thumb about decision-making as a bargaining situation with the qualifiers that I have given, then we at least have some clues as to how to intervene, how to outguess or get a glimmer of how other people in a bargaining situation are likely to move. If you can understand what it is they need and want, you might find ways to bring their decision more toward the direction that you would like it to go. By you, I mean a collectivity, an organization, a department, a group, not an individual.

Appendix A

PROGRAM

June 22, 1975		
5:00 p.m.	Registration	Daniels Hall
8:00 p.m.	Social	Home of Marvin Strauss
June 23, 1975		Faculty Club
8:15 a.m.	Coffee	
8:30 a.m.	Welcome Marvin Strauss, Coordinator, Graduate Program in Community Health Organization	
8:45 a.m.	Schedule for Institute Carol Harten, Project Director	
9:00 a.m.	Report of Kellogg Commission on Education for Health Administration Janet Strauss, M.P.H., Executive Director of the Council on Education for Public Health and former director of the Commission on Education for Health Administration	
9:30 a.m.	The National Association of Neighborhood Health Centers as a Resource for Universities Mr. Danny Davis, Executive Director West Side Health Planning Organization	
10:00 a.m.	We Agree Process Dr. Joseph Bagby Dr. Norb Buller Institute for Research and Training in Higher Education	
12:00 noon	Luncheon Official Welcome for the University Dr. Robert O'Neil, Executive Vice President of Academic Affairs	

June 24, 1975

8:30 a.m. - 4:30 p.m.	We Agree Process Continued	Faculty Club

June 25 through June 27, 1975

2:00 p.m. - 5:00 p.m.	The Ambulatory Delivery Model Roy Penchansky, D.B.A., Professor of Medical Care Organization, University of Michigan School of Public Health	215 Procter Hall

June 30, 1975

2:00 p.m. - 5:00 p.m.	Board Training: A Necessary Ingredient to Consumer Involvement Janice Forberg New Delivery Systems for Education Stephen B. Plumer, Ph.D., Educational Consultant	Queen City Room Tangeman University Center

July 1 through July 3, 1975

2:00 p.m. - 5:00 p.m.	Public Policy Issues: Implications for Inner City Health Services Nancy Milio, R.N., Ph.D., Lecturer Health Services and Public Policy, Simmons College	Queen City Room Tangeman University Center

July 7, 1975

2:00 p.m. - 5:00 p.m.	Manpower Distribution Projects Anne Warner, Program and Communications Director, Manpower Distribution Project, National Health Council Setting Course Objectives William L. Yandell, B.S.B.A., Ed.M. Program Development Specialist Community Health Planning/Administration Program	Queen City Room Tangeman University Center

July 8 through July 11, 1975

2:00 p.m. - 5:00 p.m. — International Models of Ambulatory Services; Minority Leadership in Medical Health Care; Ethics and Values in Health Care — Queen City Room, Tangeman University Center

Leslie Falk, M.D., Chairman, Department of Family and Community Health, Meharry Medical College

July 14 and July 15, 1975

2:00 p.m. - 5:00 p.m. — Response of the Health Care System to Chicano Health Care Needs: Observations from a Practitioner — Queen City Room, Tangeman University Center

Jorge Prieto, M.D., Chairman, Department of Family Practice, Cook County Hospital

July 16, 1975

2:00 p.m. - 5:00 p.m. — Future Directions of Minorities in the Health Care Systems — Queen City Room, Tangeman University Center

James G. Haughton, M.D., M.P.H., Executive Director, Health and Hospitals Governing Commission of Cook County

July 17, 1975

6:00 p.m. — Cash Bar — Faculty Club

7:00 p.m. — Closing Banquet

Speaker: James G. Haughton, M.D., M.P.H. Executive Director, Health and Hospitals Governing Commission of Cook County

July 18, 1975

8:30 a.m. - 11:30 a.m. Team Presentations

Queen City Room
Tangeman University
Center

Daily Format

Mornings - Neighborhood Health Centers

Afternoons - Seminars on Campus

Evenings - Team Work on Curriculum

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Appendix B

COMMUNITY HEALTH FORUM

Sponsored by: University of Cincinnati
Program in Community Health Organization
College of Community Services

in cooperation with: Cincinnati Area Neighborhood Health Centers and Related Facilities and The National Association of Neighborhood Health Centers

June 25, Wednesday, 8:00 p.m.

"Critical Board Decision Areas in Ambulatory Care Programs"

Roy Penchansky, D.B.A.,
Professor of Medical Organization,
University of Michigan School of
Public Health,
University of Michigan
Ann Arbor, Michigan

Cincinnati Health Department
Auditorium
3101 Burnet Avenue

July 2, Wednesday, 8:00 p.m.

"Health Services and Public Policy"

Nancy Milio, R.N., Ph.D.,
Lecturer on Health Services and
Public Policy,
Simmons College,
Boston, Massachusetts

Xavier University
Alter Hall
Kelly Auditorium

July 9, Wednesday, 8:00 p.m.

"Consumerism in Health Care Delivery; Its History in Time and Space"

Leslie Falk, M.D., Chairman,
Department of Family and Community
Health
Meharry Medical College
Nashville, Tennessee

University of Cincinnati
College of Medicine
Room E351

Lectures are open to the Public and Free